Supreme Court, U. S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77- 952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et al., Petitioners,*

v.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al., Respondents.*

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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No. 77-

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et al.*, *Petitioners*,

v.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al.*, *Respondents*.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Group Life and Health Insurance Company, Rieger/Medi-Save Pharmacies, Inc., Walgreen Texas Co. and The Sommers Drug Stores Company petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the United States District Court for the Western District of Texas is annexed hereto as Appendix A ("App. A") and is reported at 415 F.

Supp. 343. The opinion of the United States Court of Appeals for the Fifth Circuit is annexed hereto as Appendix B ("App. B") and is reported at 556 F.2d 1375.

JURISDICTION

The judgment of the Court of Appeals was entered on August 8, 1977, and is annexed hereto as Appendix C. A timely Petition For Rehearing And Rehearing En Banc was denied on October 27, 1977. *See* Appendix D. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

QUESTION PRESENTED

The McCarran-Ferguson Act ("McCarran Act") expressly renders the Sherman Act inapplicable to the "business of insurance" to the extent such business is regulated by state law, except in cases of "boycott, coercion, or intimidation". The question presented for review is whether the "business of insurance" includes direct contractual arrangements between an insurer and third parties to provide benefits owed to the insurer's policyholders when such contractual arrangements are required by the policy of insurance.

STATUTES INVOLVED

The provisions of the McCarran Act involved in this case, §§ 1, 2, 3(b), 59 Stat. 33 (1945), 15 U.S.C. §§ 1011, 1012, 1013(b) (1970), are set forth in Appendix E.

STATEMENT OF THE CASE[1]

Petitioner Group Life and Health Insurance Company, also known as Blue Shield of Texas ("Blue Shield"), is an insurance company duly authorized by the Texas State Board of Insurance to transact the business of life, health and accident insurance within the State of Texas. Petitioners Walgreen Texas Co., The Sommers Drug Stores Company and Rieger/Medi-Save Pharmacies, Inc., own and operate pharmacies in San Antonio, Texas. Respondents, plaintiffs below, are eighteen pharmacy owners and operators also doing business in San Antonio, Texas.

Respondents' antitrust action for treble damages and injunctive relief challenges Blue Shield's prepaid prescription drug insurance policies and contractual agreements under which pharmacies provide drugs to Blue Shield's policyholders and are reimbursed by Blue Shield. The purpose of the contractual agreements is to provide benefits to the insureds under the policies, and the policies obligate Blue Shield to contract with pharmacies to provide such benefits. Blue Shield's insureds are entitled to receive prescription drugs from any pharmacy. If the pharmacy selected by the insured has entered into a written contract ("Pharmacy Agreement") with Blue Shield, the insured is required to pay no more than a $2.00 deductible for each prescription. Such pharmacies are designated as "Participating Pharmacies".

Under the Pharmacy Agreement, a Participating Pharmacy agrees to dispense drugs to Blue Shield's

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[1] The operative facts are essentially uncontested and are fully and fairly set forth in the District Court opinion.

insureds, to accept $2.00 as full payment from the insured for each dispensed drug, and to bill Blue Shield for the cost of the dispensed drug. Blue Shield agrees to reimburse the Participating Pharmacy for its acquisition cost of each dispensed drug. If the insured's prescription is filled by a pharmacy other than a Participating Pharmacy, the policy provides that Blue Shield will reimburse the insured for 75% of the usual and customary charge for the drug, less the $2.00 deductible. The three pharmacy petitioners and nine of the eighteen respondents are Participating Pharmacies in the San Antonio area. The opportunity to enter into a Pharmacy Agreement has been and is available to all licensed pharmacies in the State of Texas, including each of the respondents.

This program is regulated by the State of Texas and permission for its use has been obtained from the appropriate authorities. The Texas Insurance Code requires that all new policy forms proposed to be issued by life, health, and accident insurers must be filed with the State Board of Insurance and approved, or exempted from approval, prior to issuance or use. Tex. Ins. Code Ann. art. 3.42 (1963). Blue Shield's prescription drug policy forms and the annexed Pharmacy Agreement were duly filed with the State Board prior to issuance or use, and the Commissioner of Insurance ultimately authorized their issuance and use in the State of Texas. Accordingly, Blue Shield was and is subject to all regulatory requirements of the Texas Insurance Code, including regulation of policy provisions and coverages and prohibitions on unfair competition or practices in the business of insurance. In order to implement the benefits provisions of the

policies, Blue Shield has entered into the Pharmacy Agreement with pharmacies throughout the State.

Respondents candidly admit in their complaint that in selling prepaid prescription drug insurance, Blue Shield is engaged in the "business of insurance." They contend, however, that in contracting with pharmacies to provide the policy benefits to its insureds, Blue Shield is somehow not engaged in the "business of insurance" within the meaning of the McCarran Act.

Respondents allege that the Pharmacy Agreement thus constitutes an actionable combination and conspiracy to fix retail drug prices and an agreement to cause Blue Shield's insureds to refuse to deal with certain of the respondents, in alleged violation of § 1 of the Sherman Act, 15 U.S.C. § 1 (Supp. 1977). The District Court granted petitioners' motions to dismiss for failure to state a claim on the grounds that both the policies and the Pharmacy Agreement were immunized from the Sherman Act by the McCarran Act. Relying upon this Court's decision in *SEC* v. *National Securities, Inc.*, 393 U.S. 453 (1969),[2] the District Court determined that the policies and the Pharmacy Agreement were part of the "business of insurance",

[2] In *National Securities*, this Court established the following standards for determining when the conduct of an insurance company comes within the "business of insurance":

> Certainly the fixing of rates is part of this business. . . . The selling and advertising of policies . . . and the licensing of companies and their agents . . . are also within the scope of the statute. . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the 'business of insurance.' Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. 393 U.S. at 460. (Citations omitted).

were regulated by Texas law under both the Texas Insurance Code and the State's antitrust statutes, and did not constitute a "boycott" within the meaning of the McCarran Act. In deciding the issue of whether the Pharmacy Agreement was within the term "business of insurance," the Court found that the Agreement was "based upon the provisions contained in the policies relating to coverage and benefits" and was "simply the performance of the insurer's obligations owed to its insureds under the insurance contract and nothing more." App. A, at 8a. The Court concluded that "the method adopted by Blue Shield of providing benefits under the [p]olicies is closely connected to the relationship between Blue Shield and its insureds." App. A, at 8a. Finally, the District Court held that by virtue of their contractual agreements with Blue Shield, the pharmacy petitioners had become "an integral part of the overall scheme of insurance coverage which is regulated by state law" and that this integration placed them within the "business of insurance." Thus, the Court determined that the pharmacy petitioners were also entitled to the protection afforded by the Act. App. A, at 13a.[3]

The Court of Appeals for the Fifth Circuit reversed, holding that the Pharmacy Agreement did not pertain to the relationship between Blue Shield and its insureds. Despite the District Court's findings that the Pharmacy Agreement is inextricably linked to and in fact required by the policy provisions relating to

[3] Respondents also alleged a pendent state law claim that petitioners violated the Texas antitrust laws, Tex. Bus. & Comm. Code Ann. § 15.01, *et seq.* Upon its dismissal of respondents' federal antitrust claims, the District Court also dismissed the pendent claim for lack of subject matter jurisdiction. App. A, at 14a.

benefits and coverage, the Court of Appeals concluded that "Blue Shield's policyholders are basically unconcerned with the contract between the insurer and the Participating Pharmacy."[4] App. B, at 25a.

REASONS FOR GRANTING THE WRIT

I. The Decision Below Conflicts With The Decisions Of All Other Courts Of Appeals Which Have Interpreted The Term "Business of Insurance" To Include Direct Arrangements Between Insurers And Third Parties For The Performance Of Obligations Owed To Policyholders.

The decision below stands alone and is in direct conflict with every other court of appeals decision which has had occasion to consider whether the "business of insurance" includes an insurer's dealings with third parties to satisfy obligations due to its insureds. It is a clear departure from the well established interpretation of the statutory term "business of insurance." Indeed, the Fifth Circuit frankly acknowledged that "several district courts have rendered decisions contrary to the conclusion we reach today," including "two such cases . . . affirmed on appeal." App. B, at 33a. The two Court of Appeals decisions are those in *Anderson* v. *Medical Service of the District of Columbia,* 551 F.2d 304 (4th Cir. 1977), *aff'g* 1976 Trade Cas. ¶ 60,884 (E.D. Va. 1976), and *Frankford Hospital* v. *Blue Cross of Greater Philadelphia,* 554 F.2d 1253 (3rd Cir.), *cert. denied,* —— U.S. ——, No. 77-171 (Oct. 3, 1977). In *Anderson,* the Court of Appeals held that participating agreements between

[4] Because its decision on the "business of insurance" issue was dispositive, the Court of Appeals found it unnecessary to reach the state regulation and boycott questions decided adversely to respondents in the District Court. App. B, at 22a.

a health care insurer and physicians providing services to insureds were within the "business of insurance"; in *Frankford,* the Court of Appeals rendered a similar decision on agreements between Blue Cross and hospitals providing services to Blue Cross' subscribers.

Recently, still another of the conflicting district court decisions was affirmed on appeal in an opinion which relied heavily on the District Court's opinion in this case. *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, 561 F.2d 262 (D.C. Cir. 1977), *petition for cert. pending,* No. 77-580.[5] In *Proctor,* the plaintiff automobile repair shops brought an antitrust action against automobile insurers alleging that the insurance companies had conspired to pay insureds' claims on the basis of prevailing labor rates and a common formula for computation of damage estimates, and had entered into alleged vertical arrangements to direct business to "preferred" shops and to boycott other shops. The Court of Appeals affirmed the dismissal of the complaint on "business of insurance" grounds, citing the opinion of the District Court in this case approvingly, and noting that the District Court had reached a "similar conclusion with respect to agreements between [a] medical insurance company and 'participating pharmacies,' establishing terms of reimbursement to pharmacies for drugs dispensed to policyholders." 561 F.2d at 268. The de-

[5] As well as raising a "business of insurance" issue, *Proctor* involves the question of whether the McCarran Act's "boycott, coercion, and intimidation" exception permits suits by persons other than insurers and insurance agents. The latter issue is also raised in *Barry* v. *St. Paul Fire & Marine Insurance Co.*, 555 F.2d 3 (1st Cir. 1977), *cert. granted,* No. 77-240.

cision below is squarely in conflict with the holding in *Proctor* that the insurers' determination of the amounts to be paid in fulfillment of its policy obligations was "at the heart of the relationship between insurer and insured, and is directly connected with the reliability, interpretation, and enforcement of the insurance contract." *Id.* at 267.

Yet a fourth conflicting decision is *Travelers Insurance Co.* v. *Blue Cross of Western Pennsylvania,* 481 F.2d 80 (3rd Cir.), *cert. denied,* 414 U.S. 1093 (1973), an antitrust action brought by a private insurer objecting to a standard contract between Blue Cross and hospitals "which prescribes the amounts and terms under which Blue Cross pays for the services rendered its subscribers". 481 F.2d at 82. The Court of Appeals affirmed dismissal of the complaint on McCarran Act grounds, upholding the District Court's determination "that the interrelationship of hospital payments and subscribers' rates was such that Blue Cross' arrangement with hospitals should be considered part of the 'business of insurance.'" *Id.* at 83. The fifth opinion in this series of decisions conflicting with the holding below is *Doctors, Inc.* v. *Blue Cross, of Greater Philadelphia,* 1977-1 Trade Cas. ¶ 61,420 (3rd Cir. 1977), *aff'g* Civil Action No. 73-1057 (E.D. Pa. Aug. 13, 1975), which relied on the *Travelers* decision in determining that contractual agreements between Blue Cross and hospitals constitute the "business of insurance."[6]

[6] The Fifth Circuit sought to distinguish the *Doctors, Inc.*, and *Travelers* decisions because the Pennsylvania State Insurance Commissioner "was exerting pressure on the large insurance companies to exercise their power over hospitals to reduce hospital costs" and because Pennsylvania regulated non-profit hospital rates. App. B,

In short, unlike the Court below, the Courts of Appeals for the District of Columbia, Third and Fourth Circuits all have held that the satisfaction of obligations due the insured, whether by contractual provision of goods and services with reimbursement to the provider or by claims payments to the insured, is at the "core of the 'business of insurance' " as defined by this Court in *National Securities*. 393 U.S. at 460.

The Fifth Circuit's assumption that the pharmacy petitioners are automatically ineligible for McCarran Act immunity also is in direct conflict with the decisions of two other Courts of Appeals which have held that non-insurers may be a part of the "business of insurance" for purposes of the McCarran Act exemption.[7] In *Doctors, Inc., supra,* the Court of Appeals for the Third Circuit affirmed the District Court's dismissal of the complaint as to Blue Cross and a private non-insurance health care and hospital advisory agency found to be within the "business of insurance." In *Lowe* v. *Aarco-American, Inc.,* 536 F.2d 1160 (7th Cir. 1976), the Court of Appeals held that the defendants, an insurance broker and a premium finance company, were engaged in the "business of in-

at 28a. That characterization is based on the erroneous premise that, unless there is state regulation, a company cannot be engaged in the "business of insurance". However, as the McCarran Act explicitly provides, state regulation is a second and independent element in determining whether McCarran immunity is available. The Fifth Circuit below did not consider the District Court's conclusion that Texas had both approved and regulated Blue Shield's drug insurance policies.

[7] The Court below did not examine the relationship of the pharmacy petitioners to the nature of the insurance *coverage* involved, and instead simply stated, without elaboration, that the Act affords no antitrust exemption for the "noninsurance" petitioners. App. B, at 33a.

surance," were regulated by state insurance authorities and thus were exempt from the Truth-In-Lending Act. The Court noted that "[t]here is nothing in the McCarran Act which limits the 'business of insurance' to the business of insurance companies." *Id.* at 1162. Thus, unlike the Court below, the Courts of Appeals for the Third and Seventh Circuits have recognized that the "business of insurance" includes parties engaged in providing services intimately connected to the sale or implementation of insurance policies particularly where, as here, the plan of insurance is regulated by the state. Indeed, this Court stated in *National Securities* that the Act "refers not to the persons or companies who are subject to state regulation, but to laws 'regulating the *business* of insurance.'" 393 U.S. at 459.[8] (Emphasis in original).

II. The Decision Below Jeopardizes The Existence Of Prepaid Health Insurance Plans And Will, Contrary To The Purposes Of The McCarran Act, Preempt State Regulation Of Health Insurance.

By subjecting insurers' contracts with providers of health care services to the antitrust laws, even though such contracts are an inseparable feature of prepaid health policies which are regulated by the states, the decision below threatens the viability of a new and

[8] Moreover, the protection afforded by the Act is expressly extended to, the "business of insurance, *and every person engaged therein.*" 15 U.S.C. § 1012(a). (Emphasis added). Importantly, other areas of antitrust immunity, such as organized labor, *e.g.*, Scooper Dooper, Inc. v. Krafteo Corp., 494 F.2d 840 (3rd Cir. 1974), and regulated industries, *e.g.*, Scroggins v. Air Cargo, Inc., 534 F.2d 1124 (5th Cir. 1976), have been likewise interpreted to afford the exemption to those *dealing with* one entitled to claim antitrust immunity.

growing segment of the health insurance industry. Prepaid health insurance was a response by insurers to the rapid escalation in the cost of health care services and to the urgings of federal and state officials to provide health care delivery systems which are within the financial reach of the general public. Many major health insurance companies now provide plans for physician, dental, hospital, optometric and pharmaceutical goods and services similar in concept to the one here at issue and which also involve third party providers.[9]

Prepaid health insurance obligates the insurer to furnish specified health care services to its insureds in return for premiums paid by them or on their behalf by their employer. In order to carry out its obligations under the policy, the insurer must contract with providers of health care services such as doctors, dentists, hospitals and pharmacists. By negotiating in advance the price of health care services furnished by the provider, insurers are able to offer reduced rates because, in contrast to the unpredictable costs of benefits under traditional health policies, they know the cost of the benefits they will be obligated to provide.

By removing provider agreements from the "business of insurance," the decision below places insurers in the untenable position of being regulated by the states, while simultaneously facing the possibility of

[9] Increasingly, prepaid health insurance has been among the fringe benefits negotiated in union collective bargaining agreements. Indeed, the prepaid prescription drug policies which are the subject of this case were first developed by Michigan Blue Shield pursuant to a collective bargaining agreement between the United Auto Workers and domestic automobile manufacturers.

antitrust litigation brought by providers who have chosen not to enter into participating agreements. The specter of the costs which would be incurred in even meritless litigation and the exposure to treble damages, however remote, will effectively prohibit the implementation of these plans.

The District Court recognized that where health care providers under prepaid insurance policies, such as the pharmacy petitioners here, have agreed to provide the policy benefits to Blue Shield's insureds, those providers "have become an integral part of the overall scheme of insurance coverage which is regulated by state law," and they too are entitled to protection under the Act. App. A, at 13a. Were the law otherwise, an anomolous result would be reached whereby one party, such as Blue Shield, would be free to enter into arrangements such as the Pharmacy Agreement, but there would be no one else who could safely enter into such a contract. The statutory immunity would thus be reduced to a legal fiction, without practical effect.

The decision below also infringes upon the extensive state regulation of health care plans. Substantially all of the states regulate such plans through approval of coverages (as specified in the policies and appurtenant provider agreements), rates, sales and underwriting practices and prohibitions on unfair methods of competition.[10] The application of federal antitrust standards, not specifically designed to deal with insurance availability, coverages and rates, will directly

[10] *See, E.g.*, Cal. Health and Safety Code § 1340, *et seq.* (West Supp. 1977); Mass. Laws Ann., Ch. 176G § 1, *et seq.* (1977); N.Y. Public Health Law § 440, *et seq.* (McKinney Supp. 1977); Pa. Stat. Ann., Title 40, Ch. 6 § 1401 *et seq.* (Purdon 1971).

impair the ability of the states to effectively regulate the business of insurance despite the Congressional declaration contained in the McCarran Act that "the continued regulation and taxation by the several states of the business of insurance is in the public interest." 15 U.S.C. § 1011. The effect of the decision below is to ignore this statutory mandate and to place the federal courts in the position of becoming surrogate insurance commissioners. This new and fundamental question of the manner in which insurers are to provide benefits to insureds at reasonable rates is precisely the type of question that the insurance commissioners of each state are most competent to examine through such administrative procedures as approval of rates and policy provisions. The decision below, however, limits the insurer's function to paying bills and deprives insurers of the ability to negotiate the costs of benefits in order to reduce rates and increase coverages.

If state regulation of the business of insurance is to be subordinated to the federal antitrust laws, it should only be after statutory revision by Congress or upon plenary consideration by this Court.

CONCLUSION

The federal courts are being increasingly burdened with a profusion of antitrust cases involving health insurance plans and provider agreements. Until the decision below, the lower courts have uniformly held such plans and agreements to be part of the "business of insurance," subject to state regulation and thus, absent boycott, beyond the reach of the federal anti-

trust laws.[11] The clear conflict created by the decision below and the uncertainty it engenders makes it appropriate—indeed, necessary—for this Court to delineate the boundaries between federal and state regulation. This Court should resolve the conflict that has now arisen regarding the fundamental threshold question under the Act: what activities constitute the

[11] In addition to the cases previously cited herein, the Fifth Circuit notes that its decision is also in conflict with the decisions in Manasen v. California Dental Services, 424 F. Supp. 657 (N.D. Cal. 1976) (participating dentist agreements); Schwartz v. Commonwealth Land Title Insurance Co., 374 F.Supp. 564 (E.D. Pa. 1974) (rating bureau for title insurance companies immune); Nankin Hospital v. Michigan Hospital Service, 361 F.Supp. 1199 (E.D. Mich. 1973) (participating hospital agreements); and California League of Independent Insurance Producers v. Aetna Casualty & Surety Co., 175 F.Supp. 857 (N.D. Cal. 1959) (commissions paid to agents within the "business of insurance"). Conflicting decisions not mentioned by the Fifth Circuit include St. Bernard General Hospital v. Hospital Service Association of New Orleans, Inc., Civil Action No. 71-2493 (E.D. La., Oct. 13, 1977) (participating hospital agreements); Workman v. State Farm Mutual Automobile Ins. Co., Civil Action No. 75-1799 (N.D. Cal., Sept. 16, 1976) (arrangements between automobile insurer and automobile body repair shops constitute the business of insurance); Winters v. Kansas Hospital Service Ass'n., 1975-1 Trade Cas. ¶ 60,140 at 65,386 (D. Kan. 1974) (hospital agreements); and Holly Springs Funeral Home, Inc. v. United Funeral Service, Inc., 303 F.Supp. 128 (N.D. Miss. 1969) (arrangements for provision of funeral services under burial insurance policies—funeral homes immune).

"business of insurance"? The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A

Opinion of United States District Court for the Western District of Texas, June 23, 1976

ROYAL DRUG COMPANY d/b/a Royal Pharmacy of Castle Hills and Disco Prescription Pharmacy et al.

v.

GROUP LIFE AND HEALTH INSURANCE COMPANY a/k/a Blue Shield and/or Blue Cross-Blue Shield of Texas, et al.

Civ. A. No. SA-75-CA-131.

UNITED STATES DISTRICT COURT,
W. D. TEXAS
SAN ANTONIO DIVISION

June 23, 1976.

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Memorandum Opinion

JOHN H. WOOD, Jr., *District Judge.*

I.

Plaintiffs in this private civil antitrust action are eighteen independent pharmacy owners doing business in San Antonio, Texas. Defendant Group Life and Health Insur-

ance Company, also known as Blue Shield of Texas ("Blue Shield"), is an insurance company duly authorized by the Texas State Board of Insurance to transact the business of life, health and accident insurance within the State of Texas. The remaining three Defendants, Walgreen Texas Co. ("Walgreen"), The Sommers Drug Stores Company ("Sommers"), and Rieger/Medi-Save Pharmacies, Inc. ("Rieger") operate pharmacies in San Antonio, Texas.

Plaintiffs' suit is an attack upon Blue Shield's plan of operation under certain prescription drug insurance policies (the "Policy") which it issues. It is alleged that Defendants have violated Section 1 of the Sherman Act, 15 U.S.C. § 1, by agreeing, combining and conspiring to fix the retail price of drugs and pharmaceuticals, and that the activities of Defendants have caused Blue Shield's insureds not to deal with certain of the Plaintiffs, thereby constituting a group boycott. Plaintiffs further allege that Defendants have violated the Texas antitrust laws, Tex. Bus. & Comm.Code Ann. § 15.01, *et seq.*, and that this Court should exercise pendent jurisdiction over those claims.

Each of the Defendants has separately moved to dismiss the Complaint for lack of jurisdiction over the subject matter and for failure to state a claim upon which relief can be granted. Defendants' motions are based upon the provisions of the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.* The motions also urge that in the absence of any valid cause of action based upon federal law, this Court should dismiss Plaintiffs' pendent claims.

Extensive discovery has been completed on the issue presently before the Court. The record includes numerous depositions, affidavits and documents, and all parties have had full opportunity to present all materials pertinent to Defendants' motions. The Court has carefully reviewed and considered all of those materials, together with the briefs submitted by the parties and the oral argument of counsel.

The facts relevant to Defendants' motions are undisputed. The Policies provide prescription drug insurance coverage. The benefits provided under the Policies entitle Blue Shield's insureds to receive prescription drugs from any pharmacy (a "Participating Pharmacy") that has entered into a written contract (the "Pharmacy Agreement") with Blue Shield. The Policies further provide that the insured is required to pay no more for each prescription filled by a Participating Pharmacy than the amount of the drug deductible set forth in the Policy. The drug deductible is $2.00. Pursuant to the terms of the Pharmacy Agreement, a Participating Pharmacy agrees to dispense drugs to Blue Shield's insureds and to accept $2.00 as full payment from the insured for each dispensed drug. Further, Blue Shield agrees to reimburse the Participating Pharmacy for the acquisition cost of each drug dispensed to its insureds. Under the terms of the Policy, if the insured has his prescriptions filled by a pharmacy other than a Participating Pharmacy, he must pay the full price charged by the pharmacy and then apply to Blue Shield for reimbursement. Blue Shield will then reimburse the insured for 75% of the usual and customary charge for the drug, less the $2.00 deductible.

Walgreen, Sommers and Rieger each own Participating Pharmacies. Blue Shield is not engaged in selling or dispensing prescription drugs as a manufacturer, wholesaler or retailer, but is engaged solely in transacting the business of life, health and accident insurance.

In 1969, Blue Shield sought authority from the Texas State Board of Insurance to begin issuing prescription drug insurance coverage in the form described above. Article 3.42 of the Texas Insurance Code provides that all new policy forms proposed to be issued by life, health and accident insurance companies must be filed with the State Board of Insurance and approved prior to issuance or use by the company. In March, 1969, Blue Shield filed with the

State Board of Insurance a proposed form of the Policy and the Pharmacy Agreement for approval prior to their issuance or use. The terms of the policy provided that Blue Shield's insureds were entitled to receive prescription drugs from Participating Pharmacies (called "participating providers" in the Policy). The Policy defined the term "participating provider" as a pharmacy who "has entered into a written contract [with Blue Shield] for the rendition of covered drugs for which benefits are provided by this [policy]." The Pharmacy Agreement was in the form described above.

In June, 1969, the Commissioner of Insurance issued a written order disapproving the issuance or use of the Policy. The Commissioner also notified the Texas Attorney General in writing of the action taken by the State Board and provided the Attorney General with copies of all pertinent documents. As a result of the disapproval order, Blue Shield did not issue or use the Policy or the Pharmacy Agreement.

Subsequent to the issuance of the disapproval order, the Policy and the Pharmacy Agreement remained under consideration by the State Board of Insurance. In September, 1969, pursuant to Article 3.42(e) of the Texas Insurance Code,* the Commissioner of Insurance issued another written order exempting the Policy from the approval requirements of Tex.Ins.Code Ann. art. 3.42.

The exemption order issued by the Commissioner of Insurance provided, in pertinent part:

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* "The Board of Insurance Commissioners may, by written order, exempt from the requirements of this Article for so long as it deems proper, any insurance document or form specified in such order to which in its opinion this Article may not practicably be applied, or the filing and approval of which are, in its opinion, not desirable or necessary for the protection of the public." Tex. Ins.Code Ann. art. 3.42(e).

"Pursuant to the authority granted by Article 3.42, Paragraph (e) of the Texas Insurance Code, the Commissioner of Insurance hereby exempts from the requirements of said Article Policy Form CC-OHDS-2 submitted by Group Life and Health Insurance Company, Dallas, Texas; and this exemption shall remain effective pending further orders from the Commissioner of Insurance.

"The exempt forms are described as drug service contracts, which confer upon the policy holder the right to obtain certain prescribed drugs at a cost fixed in the contract, the insurer having entered into participating agreements with dispensing pharmacies to supply the prescribed drugs to its policy holders."

It is clear that the exemption order exempted the Policy from nothing more than the requirement of approval by the State Board of Insurance. The former Deputy Commissioner of Insurance, who reviewed the Policy and the Pharmacy Agreement and then prepared the exemption order for the Commissioner's signature, testified on oral deposition that exempted policies are subject to all statutory requirements of the Texas Insurance Code and all regulatory requirements of the State Board of Insurance. He further testified that exempted policies and approved policies are subject to the same continuing regulation, control and supervision by the State Board. Other officials of the State Board of Insurance testified on oral deposition that exempted policies and approved policies are treated alike within the regulatory framework of the State Board of Insurance.

Further, the exemption order clearly shows that the Commissioner of Insurance considered the Pharmacy Agreement together with the Policy prior to issuing the exemption order. The exemption order authorized Blue Shield to issue and use the Policy in the State of Texas in

the same manner as if it had been approved. Subsequent to the issuance of the exemption order, the Commissioner again advised the Texas Attorney General in writing of his action and forwarded a copy of the exemption order to the Attorney General. The exemption order has not been modified or rescinded.

Thereafter, Blue Shield made a statewide mailing to licensed pharmacies offering them the option of entering into the Pharmacy Agreement. Subsequent to the issuance of the exemption order, Blue Shield has issued the policy to various groups and entered into the Pharmacy Agreement with pharmacies throughout the State of Texas.

In 1974, Blue Shield entered into a health care agreement to provide insurance benefits to groups in Bexar County, Texas. Included in the proposed coverage was prescription drug insurance. In September, 1974, pursuant to Tex.Ins.Code Ann. art. 3.42, a Policy form virtually identical to the one submitted in 1969 was filed with the State Board of Insurance for approval prior to issuance or use in connection with the Bexar County program. Thereafter, in October, 1974, the Commissioner of Insurance issued a written order approving the Policy for issuance. Since receipt of the approval order, Blue Shield has issued the Policy to various groups in Bexar County, Texas. Blue Shield offered to virtually all licensed pharmacies in San Antonio, Texas, the opportunity of entering into a Pharmacy Agreement. Nine of the Plaintiffs accepted Blue Shield's offer and now operate Participating Pharmacies.

Plaintiffs agree that Blue Shield is engaged in the business of issuing prescription drug insurance coverage; however, they contend that the McCarran-Ferguson exemption is inapplicable in that Blue Shield has exceeded the business of insurance by entering into the Pharmacy Agreements, and that such agreements have nothing to do with the business of insurance. Plaintiffs further contend that regardless of whether or not Blue Shield is engaged in the

business of insurance, Walgreen's, Sommers' and Rieger's participation in the Pharmacy Agreement is not the business of insurance.

For the reasons set forth herein, this Court does not agree with Plaintiffs' contentions. It is clear that the terms of the Policies which were reviewed by the State Board of Insurance and which it authorized Blue Shield to issue, expressly contemplate the execution of Pharmacy Agreements between Blue Shield and Participating Pharmacies. Moreover, the Pharmacy Agreement is so integrally related to the Policies that it would be impossible for Blue Shield to fulfill its contractual obligations to its insureds in the absence of such agreements.

The McCarran-Ferguson Act provides that ". . . the Sherman Act, . . . the Clayton Act, and the . . . Federal Trade Commission Act . . . shall be applicable to the business of insurance to the extent that such business is not regulated by State law." 15 U.S.C. § 1012(b). To the extent a state regulates such business by state law, the Sherman Act and the other federal antitrust laws are not applicable. The exemption is effective provided that two criteria are met: (1) that the "business of insurance" is involved, and (2) that there is state regulation of the business of insurance. The McCarran-Ferguson Act does not apply to acts of "boycott, coercion or intimidation." 15 U.S.C. § 1013(b).

II.

The Business of Insurance

In *SEC v. National Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564, 21 L.Ed.2d 668 (1969), the Supreme Court held that the "business of insurance" includes the relationship between the insurer and insured; the type of policy which could be issued, its reliability, interpretation and enforcement; and other activities of insurance companies which closely relate to their status as reliable insurers. *Id.* at 460,

89 S.Ct. 564. The Pharmacy Agreement directly pertains to the relationship between Blue Shield and its insureds. Moreover, the Pharmacy Agreement is a *direct* contractual relationship between the insurer and a provider of benefits, the result of which is simply the performance of the insurer's obligations owed to its insureds under the insurance contract and nothing more. A similar *direct* contractual relationship was examined in *Travelers Ins. Co. v. Blue Cross of West. Pennsylvania,* 481 F.2d 80 (3rd Cir. 1973) *cert. denied,* 414 U.S. 1093, 94 S.Ct. 724, 38 L.Ed.2d 550 (1973). In that case, the Third Circuit held that such contractual arrangements constituted the business of insurance, and thus, the relationship fell within the McCarran-Ferguson exemption. Direct contractual relationships between the insurer and a provider of benefits, as in this case, plainly relate to the "relationship between insurer and insured." The Pharmacy Agreement is based upon the provisions contained in the Policies relating to coverage and benefits, and directly concerns matters of interpretation and enforcement of the Policies. Clearly, the method adopted by Blue Shield of providing benefits under the Policies is closely connected to the relationship between Blue Shield and its insureds. The activities challenged by Plaintiffs in this action, including Blue Shield's contractual arrangements with Participating Pharmacies, constitute the business of insurance within the meaning of *SEC v. National Securities, Inc., supra.*

A program substantially similar in concept and operation to the one at issue was previously determined by the Texas Attorney General to constitute the business of insurance in the State of Texas. In response to a request for an opinion from the Texas Commissioner of Insurance, the Attorney General analyzed a prescription drug program which contemplated the filling of subscriber's prescriptions by participating pharmacies. The plan of operation was based upon a contract between the company and participating pharmacies, whereby the pharmacy agreed to charge

the subscriber no more than a certain percentage of the retail price of the prescription, and the company agreed to reimburse the pharmacy for the remainder. After thoroughly discussing the program the Attorney General concluded that ". . . the plan of operation intended to be followed by Prepaid Prescription Plan, Inc. would involve the doing of an insurance business in this state". Texas Attorney General's Opinion No. WW-1475 (Dec. 11, 1962).

This Court concludes that Blue Shield's plan of operation under the prescription drug insurance Policies, including the Pharmacy Agreements, constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act.

III.

State Regulation

A. *General Regulation.*

The McCarran-Ferguson Act renders the federal antitrust laws inapplicable when state legislation generally proscribes, permits, or otherwise regulates the conduct in question and authorizes enforcement through a scheme of administrative supervision. *Crawford v. American Title Ins. Co.,* 518 F.2d 217 (5th Cir. 1975); *FTC v. National Cas. Co.,* 357 U.S. 560, 78 S.Ct. 1260, 2 L.Ed.2d 1540 (1958); *Commander Leasing Co. v. Transamerica Title Ins. Co.,* 477 F.2d 77 (10th Cir. 1973).

The State of Texas has actively regulated the activities challenged in Plaintiff's Complaint since the inception of Blue Shield's prescription drug insurance program. The requirement of Article 3.42 of the Texas Insurance Code that all policy forms must be filed for review and approval by the State Board of Insurance prior to issuance or use by the insurer was fully satisfied. Active regulation of the prescription drug insurance program is further shown by the written orders issued by the Commissioner of Insurance and by the fact that the Texas Attorney General was

also kept fully advised of Blue Shield's prescription drug insurance program.

B. *Regulation Of Unfair Methods Of Competition In The Business of Insurance.*

Not only is there a scheme of general state regulation of the business of insurance involved in this action, but the Texas Insurance Code contains specific provisions applicable to the conduct alleged in Plaintiffs' Complaint. In 1951, the Texas Legislature enacted Tex.Ins.Code Ann. art. 21.21, which expressly regulates unfair competition and unfair practices in the business of insurance. The declaration of purpose of the Act states:

> "The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress) [the McCarran-Ferguson Act], by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined." Tex.Ins.Code Ann. art. 21.21 § 1.

Article 21.21 specifically prohibits "*any* trade practice which is defined in [the] Act as, or determined pursuant to [the] Act to be, an unfair method of competition or unfair or deceptive act or practice in the business of insurance." Tex.Ins.Code Ann. art. 21.21 § 3. (Emphasis added) That statute grants specific administrative and supervisory powers to the State Board of Insurance, including the power to issue cease and desist orders. Penalties are provided for violation of such orders. Without doubt, the phrase "any" unfair method of competition encompasses the conduct challenged in this action. Furthermore, the oral deposition testimony establishes that the State Board of Insurance reviews all policy forms submitted to it with a view toward

insuring compliance with Article 21.21, and that approved, as well as exempted policies, are subject to its provisions. Article 21.21 was specifically intended by its drafters to respond to the invitation of the McCarran-Ferguson Act and to withdraw from federal control the very conduct charged by Plaintiffs in this action, and to place such conduct under state control. Article 21.21 constitutes sufficient state regulation to activate the exemption provided in the McCarran-Ferguson Act. *Crawford v. American Title Ins. Co.*, 518 F.2d 217 (5th Cir. 1975); *Dexter v. Equitable Life Assurance Soc'y of the U. S.*, 527 F.2d 233 (2nd Cir. 1975).

C. *The Texas Antitrust Laws.*

In addition to the comprehensive regulation of Blue Shield's activities provided by the Texas Insurance Code, anticompetitive practices in the business of insurance are also regulated by the Texas antitrust laws. The Texas antitrust laws declare categorically that "[e]very monopoly, trust, and conspiracy in restraint of trade . . . is illegal and prohibited." Tex.Bus. & Comm. Code Ann. § 15.04(a). Further, the Texas antitrust laws specifically prohibit conspiracies of the type alleged in Plaintiffs' Complaint. Tex. Bus. & Comm.Code Ann. § 15.02. It should be noted that Plaintiffs have included in their Complaint a pendent claim under the Texas antitrust laws based upon the same facts that Plaintiffs allege give rise to a violation of the federal antitrust laws.

The existence of a state antitrust law proscribing the conduct complained of constitutes "regulation" within the meaning of the McCarran-Ferguson Act sufficient to displace the federal antitrust laws. *Meicler v. Aetna Cas. and Sur. Co.*, 506 F.2d 732 (5th Cir. 1975); *Sanborn v. Palm*, 336 F.Supp. 222 (S.D.Tex.1971); *Transnational Ins. Co. v. Rosenlund*, 261 F.Supp. 12 (D.Ore.1966); *California League of Ind. Ins. Producers v. Aetna Cas. & Sur. Co.*, 175 F.Supp. 857 (N.D.Cal.1959).

Therefore, in addition to active regulation under the Texas Insurance Code, the existence of state antitrust statutes forbidding the conduct alleged by Plaintiffs constitutes state regulation of the business of insurance sufficient to bar application of the federal antitrust laws.

IV.

The Boycott Exception to the McCarran-Ferguson Act Is Inapplicable

As in *Meicler v. Aetna Cas. and Sur. Co., supra,* Plaintiffs attempt to avoid the effect of the McCarran-Ferguson exemption by relying on the Section 1013(b) boycott exception. Plaintiffs' reliance on this exception is misplaced. The courts have narrowly construed Section 1013(b), which provides:

> "Nothing contained in this chapter shall render said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion or intimidation." 15 U.S.C. § 1013(b).

The sole purpose of this exception is to protect against the issuance of black-lists naming insurance companies or agents, rather than the conduct alleged by Plaintiffs in this action.

In *Meicler*, the Court stated:

> "As the district court noted, the legislative history indicates that the boycott exception was designed to reach insurance company 'black-lists' rather than refusal to sell to a particular segment of the public at other than a specified price. (Citations omitted) Appellants' broad construction of Section 1013(b) would emasculate the antitrust exemption contained in Section 1012(b) of the McCarran-Ferguson Act. We affirm the district court's holding that the boycott exception does not apply." 506 F.2d at 734.

This case does not involve black-listing and the boycott exception is inapplicable. *Addrisi v. Equitable Life Ins. Assurance Soc'y of the U. S.,* 503 F.2d 725 (9th Cir. 1974); *Proctor v. State Farm Mut. Auto Ins. Co.,* 406 F.Supp. 27 (D.D.C.1975); *Mitgang v. Western Title Ins. Co.,* Trade Reg.Rep. (1974-2 trade cases) ¶ 75,322 at 98,024 (N.D.Cal. October 16, 1974); *Transnational Ins. Co. v. Rosenlund,* 261 F.Supp. 12 (D.Or.1966).

V.

Application of the McCarran-Ferguson Act to the Non-Insurance Company Defendants

Plaintiffs contend that Walgreen, Sommers and Rieger are not entitled to the protection afforded by the McCarran-Ferguson Act because they are not insurance companies. The exemption provided in the Act is not strictly limited to insurance companies. As shown herein, it is the "business of insurance" with which the Act is concerned.

Recent cases have allowed the exemption even though the challenged activities involved parties other than insurance companies. In *Travelers Ins. Co., v. Blue Cross of West. Pennsylvania,* 481 F.2d 80 (1973), the Court applied the exemption to contracts between the insurance company and hospitals. In *Schwartz v. Commonwealth Land Title Ins. Co.,* 374 F.Supp. 564 (E.D.Pa. 1974), the exemption was applied to a fee charged to sellers of real estate by title insurance companies and agents.

It is clear that it is the nature of the conduct involved which must be looked at in order to determine whether or not the exemption should be applied. In the instant case, Walgreen, Sommers and Rieger, by having contractually agreed with Blue Shield to provide the benefits set out in the Policy, have become an integral part of the overall scheme of insurance coverage which is regulated by state law. Such integration of the providers of benefits under the

Policies into the overall scheme places their actions under the Pharmacy Agreements within the "business of insurance", and they are therefore entitled to the protection afforded by the McCarran-Ferguson Act for it is clear that one cannot be brought within the web of potential liability under the Federal Antitrust laws for participation in the complained of activity if such activity is, as in the instant case, exempt by operation of the McCarran-Ferguson Act.

VI.

Plaintiff's Pendent Claims

As shown above, the complained of activities are exempt from the Federal Antitrust laws because of the McCarran-Ferguson Act. It is clear from the pleadings on file that jurisdiction over this action does not exist by reason of diversity of citizenship. If the Federal claims are dismissed prior to trial, it is within the ambit of this Court's discretion to decline to continue to exercise jurisdiction over the pendent state claims. No unusual circumstances are present in this case which would require the Court to retain jurisdiction over the pendent claims. *United Mine Workers of America v. Gibbs,* 383 U.S. 715, 86 S.Ct. 1130, 16 L.Ed.2d 218 (1966); *Lazier v. Weitzenfeld,* 505 F.2d 896 (5th Cir. 1975); *Kavit v. A. L. Stamm & Co.,* 491 F.2d 1176 (2nd Cir. 1974).

VII.

Conclusion

For the reasons set forth above, this Court concludes that the complained of activities constitute the "business of insurance". This Court further concludes that the State of Texas has regulated and is actively and effectively regulating such business of insurance within the meaning of the McCarran-Ferguson Act, and the Federal Antitrust laws are thereby rendered inapplicable. Accordingly, Defend-

ants' motions will be granted. As shown herein, this Court has considered matters outside the pleadings in arriving at its decision. In doing so, the essentials necessary to support the exemption have been found to exist. Therefore, it is appropriate that Defendants' motions shall be treated as Motions for Summary Judgment and disposed of as provided in Rule 56, Federal Rules of Civil Procedure. The foregoing Memorandum Opinion constitutes the Court's Findings of Fact and Conclusions of Law.

An Order consistent with the foregoing will be entered.

APPENDIX B

Opinion of United States Court of Appeals for the Fifth Circuit, August 8, 1977

ROYAL DRUG COMPANY, INC., d/b/a Royal Pharmacy of Castle Hills and Disco Prescription Pharmacy, et al., *Plaintiffs-Appellants,*

v.

GROUP LIFE AND HEALTH INS. Co., a/k/a Blue Shield and/or Blue Cross-Blue Shield of Texas, et al., *Defendants-Appellees.*

No. 76-2746.

UNITED STATES COURT OF APPEALS, FIFTH CIRCUIT.

Aug. 8, 1977.

Rehearing and Rehearing En Banc Denied Oct. 27, 1977.

* * *

Joel H. Pullen, Stephen F. Lazor, San Antonio, Tex., for plaintiffs-appellants.

Keith E. Kaiser, R. Laurence Macon, J. Burleson Smith, San Antonio, Tex., for Group Life & Health.

William C. Church, Jr., San Antonio, Tex., for Walgreen Texas Co.

Richard B. Moore, San Antonio, Tex., for Sommers Drug Stores Co.

Charles R. Shaddox, San Antonio, Tex., for Rieger-Medi-Save Pharmacies, Inc.

Appeal from the United States District Court for the Western District of Texas.

Before GOLDBERG and HILL, Circuit Judges, and KERR,* District Judge.

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* Senior District Judge for the District of Wyoming, sitting by designation.

JAMES C. HILL, Circuit Judge:

The plaintiffs in this civil antitrust action are eighteen independent pharmacy owners doing business in San Antonio, Texas.[1] Blue Shield is a Texas insurance company authorized by the State Board of Insurance of Texas to sell life, health and accident insurance. Three other defendants, Walgreen Texas Company, The Sommers Drug Stores Company and Rieger Medi-Save Pharmacies, Inc., also operate pharmacies in San Antonio, Texas.

The plaintiffs contend that the defendants have violated Section 1 of the Sherman Act, 15 U.S.C. § 1, by agreeing, combining and conspiring to fix the retail price of drugs and pharmaceuticals, and that the activities of the defendants have caused Blue Shield's insureds not to deal with certain of the plaintiffs, thereby constituting an unlawful group boycott. Plaintiffs also allege violations of Texas antitrust law over which the district court took pendent jurisdiction. The defendants affirmatively alleged in their answers that pursuant to the provisions of the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.*, ("McCarran Act") the complaint failed to state a claim upon which relief could be granted and that the district court lacked subject matter jurisdiction. On the basis of the McCarran Act, each defendant moved to dismiss the complaint pursuant to Rule 12(b), F.R.Civ.P. The defendants also moved that the court treat their motions as motions for summary judgment pursuant to Rule 56, F.R.Civ.P. Defendants further moved the court to dismiss the claims based upon state law if the court found there was not a proper cause of action based upon federal law. The district court held that: (1) the conducted complained of by

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[1] Since the parties have been referred to in the briefs as plaintiffs and defendants, as they were in the district court, they will be so designated in this opinion. The defendant Group Life & Health Insurance Company will be referred to herein as Blue Shield.

the plaintiffs constitutes the business of insurance; (2) the State of Texas has regulated and is actively regulating such business of insurance within the meaning of the McCarran Act; (3) that the boycott exception to the McCarran Act is inapplicable to the instant case; and (4) that the federal antitrust laws are, therefore, rendered inapplicable. We reverse.

I. *The Facts.*

Plaintiffs are challenging a plan of operation under which Blue Shield issues certain prescription drug insurance policies which entitle Blue Shield's insureds to purchase drugs from any pharmacy. If the pharmacy selected by the policyholder has entered into a written contract ("Pharmacy Agreement") with Blue Shield, the insured is required to pay only two dollars ($2.00), the amount of the drug deductible set forth in the policy. On the other hand, if the insured has his prescription filled by a pharmacy other than a Participating Pharmacy, he is required to pay the full price charged by the pharmacy as well as the $2.00 deductible, and then to apply to Blue Shield for reimbursement. Blue Shield will then reimburse the insured only for 75 percent of the usual and customary charge for the drug, less the $2.00 deductible.[2]

In 1969, Blue Shield sought approval from the Texas State Board of Insurance to begin issuing prescription drug insurance coverage. The Commissioner, however, disapproved the issuance or use of such a policy. The policy remained under the consideration of the Commissioner and in September, 1969, the Commissioner issued an order exempting the policy from the approval requirements of Texas law. The defendants contend that there is uncontradicted evidence showing that an exemption order exempts the policy from nothing more than the require-

[2] The usual and customary charge is established by Blue Shield and is determined by reference to its compilation of such charges.

ment of approval by the State Board of Insurance, and that exempted policies, as well as approved policies, are subject to all statutory requirements of the Texas Insurance Code and the continuing regulation, control and supervision of the State Board of Insurance.

When the Commissioner issued his orders concerning the plan, disapproving it in the first instance, and then exempting the plan, he advised the Texas Attorney General in writing of his actions on each occasion. After receiving the exemption order, Blue Shield made a statewide mailing to licensed pharmacies offering them the privilege of entering into the Pharmacy Agreement. As a result, Blue Shield has issued the policy to various groups and has entered into the Pharmacy Agreemnt with pharmacies throughout the State of Texas.

In 1974, Blue Shield entered into a health care agreement, which included a prescription drug insurance, to provide insurance benefits to groups in Bexar County, Texas. In order to implement this agreement, in September, 1974, a policy form virtually identical to the one submitted in 1969 was filed with the State Board of Insurance for approval prior to its issuance or use. This policy was approved in October, 1974. Subsequently, Blue Shield has issued the policy to various groups in Bexar County and has offered to virtually all licensed pharmacies in San Antonio the opportunity of entering into the Pharmacy Agreement. Nine of the plaintiffs in this case accepted Blue Shield's offer and now operate Participating Pharmacies. In recent years, the number of pharmaceutical sales covered by this policy have risen dramatically. For example, between early 1972 and October, 1975, there was a 3,100 percent increase in the number of pharmaceutical claims processed by Blue Shield under the policy. In October, 1975, Blue Shield was handling these claims at the rate of approximately 31,000 claims per month as compared with only 1,000 claims per month in early 1972.

For each sale made under the plan, a Participating Pharmacy is limited to a $2.00 markup, which is known as a "professional dispensing fee," irrespective of its actual acquisition cost for a particular drug. The plaintiffs note that, with respect to highly expensive drugs, the Pharmacy Agreement can result in a markup of no more than two percent, which will not even cover the interest on its investment inventory.

II. *Summary of Contentions on Appeal.*

The plaintiffs argue that the retail sales price, as fixed in the Pharmacy Agreement between Blue Shield and the defendant pharmacy chains, has been set at a level below that at which small independent pharmacies can profitably conduct business. They claim that only large, high volume chains that sell many items in addition to drugs can afford to operate pursuant to the Pharmacy Agreement. They also contend that the Agreement fixes the retail price of drugs at a level which eliminates the only effective means by which small independent pharmacies can compete with the large chains—the provision of services. They argue that, since signatories of the Pharmacy Agreement are limited to the same retail sales price whether they provide home deliveries, twenty-four service, or no service at all, the ability of the independents to compete is effectively destroyed. The plaintiffs contend that Blue Shield's plan of operation not only encompasses the fixing of prices in the defendant pharmacy chains, but it extends to the pharmaceutical industry as a whole. They contend that small independent pharmacies are given the choice of either signing the price fixing agreement or being forced out of business.

The plaintiffs also argue that there are two types of coercion of Blue Shield's subscribers inherent in the plan. First, the subscriber received markedly reduced benefits if he patronizes a pharmacy that refuses to sign the price-

fixing agreement. Although he would pay only the $2.00 drug deductible for each prescription filled by a participating pharmacy, he would ultimately pay an amount representing 25 percent of a reasonable charge for the drug, in addition to the $2.00 drug deductible, for each prescription filled by a nonsigning pharmacy. The plaintiffs also point out that the differential in benefits between participating and nonparticipating pharmacies is intended to coerce Blue Shield's policy holders not to patronize nonsigning pharmacies *in Texas* and thereby to coerce such pharmacies to sign the price-fixing agreement. This allegation is based on the policy itself, which provides that the subscriber will be reimbursed 100 percent of a reasonable charge for the drug, less the $2.00 drug deductible, when he patronizes a nonsigning pharmacy outside the State of Texas.

The plaintiffs also contend that there is a second and more subtle step to the coercion. If a pharmacy signs the Pharmacy Agreement and agrees to charge only the stipulated amount for drugs sold to Blue Shield subscribers, it will be reimbursed directly by Blue Shield in the amount of the acquisition cost, and the subscriber will be obligated to pay the pharmacy at the time of purchase only the $2.00 drug deductible. If the pharmacy has refused to sign the Agreement, however, Blue Shield will not deal with the pharmacy directly, and the subscriber must pay the entire retail sales price at the time of purchase, in addition to the $2.00 fee. After paying the entire sales price at the time of purchase, he must file a claim with Blue Shield seeking reimbursement. Thus, an insured has the additional burden of filing a claim for reimbursement, and he must accept reduced benefits in order to patronize the drug store of his choice.

Having made the above claims, the plaintiffs are immediately confronted with defendant's argument that its activities are exempt from the antitrust laws by virtue of

the McCarran Act. The McCarran-Ferguson Act provides that the Sherman Act, the Clayton Act and the Federal Trade Commission Act shall be applicable to the business of insurance only "to the extent that such business is not regulated by state law."

Disputing the applicability of the McCarran Act exemption, the plaintiffs contend that a three-step analysis is necessary to determine whether an insurance company's challenged activities fall within the Act's exemption. First, they contend, the court must determine whether the challenged activities constitute the "business of insurance." Second, it must determine whether the activities in question are regulated by state law. Third, the court must determine the presence or absence of boycott, coercion, or intimidation.[3] The latter requirement derives from Section 3(b) of the McCarran Act, which states as follows: "Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate or act of boycott, coercion or intimidation." 15 U.S.C. §1013(b) (1970).

III. *Do the Defendants' Activities Constitute the Business of Insurance?*

The stepping off point of our analysis is the general principle that statutory exceptions to the antitrust laws "are to be strictly construed." *Abbott Labs v. Portland Retail Druggists Ass'n, Inc.*, 425 U.S. 1, 96 S.Ct. 1305, 47 L.Ed.2d 537 (1976); *FMC v. Seatrain Lines, Inc.*, 411 U.S. 726, 93 S.Ct. 1773, 36 L.Ed.2d 620 (1973). The notion

[3] A negative finding for the first question obviates the necessity for a determination with respect to the second and third steps, and precludes application of the McCarran Act. *SEC v. Nat'l Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564, 21 L.Ed.2d 668 (1969); *American General Insurance Co. v. FTC*, 359 F.Supp. 887 (S.D. Tex. 1973), *aff'd.*, 496 F.2d 197 (5th Cir. 1974).

that "our cases have repeatedly established . . . a *heavy presumption against* implicit [antitrust] exemptions" was recently reaffirmed in *Abbott Labs, supra.*[4] Moreover, it is clear that merely because challenged conduct has been engaged in by an insurance company does not dictate its characterization as the "business of insurance" under the McCarran Act. *SEC v. National Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564, 21 L.Ed.2d 668 (1969). The question presented under the McCarran Act, therefore, "is whether the activities complained of, *even though they may be actions taken by an insurance company,* are part of the 'business of insurance' which Congress sought to remove from federal regulation." *Fry v. John Hancock Mutual Life Ins. Co.*, 355 F.Supp. 1151, 1153 (N.D.Tex.1973) (emphasis added).

In *National Securities* the Supreme Court held that the "business of insurance" included (1) "the relationship between insurer and insured," (2) "the type of policy which could be issued, its reliability, interpretation and enforcement;" (3) "other activities which relate . . . to their status as reliable insurers." Relying on the first of these definitions, the plaintiffs note that the McCarran Act's focus is on the relationship between the insurer and the insured. The plaintiffs argue that a crucial determination is the question how closely the challenged activity concerns the relationship between the insurance company and the policyholder. The activities challenged herein, according to the plaintiffs, relate primarily to relationships other than that between the insurer and its policyholders and therefore are not peculiar to the insurance industry. The plaintiffs concede that there may be effects on policyholders resulting from the Pharmacy Agreement, but they

[4] Relying on this general principle, plaintiffs argue that if the challenged activities do not clearly constitute the business of insurance, they fall outside the McCarran Act's protective umbrella and are subject to the full force and effect of the antitrust laws.

minimize these as peripheral and secondary to the effects on the relationships between competing pharmacies and between such pharmacies and their customers.

The defendants contend, and the district court found, that the plan of operation followed by Blue Shield, including the Pharmacy Agreement, relates directly to its status as a reliable insurer. We cannot agree. It is beyond peradventure that every action taken by an insurance company to enhance its status as a "reliable insurer" does not necessarily constitute the "business of insurance" within the meaning of the McCarran Act. Moreover, an agreement which does not otherwise constitute the business of insurance is not automatically embraced within the protection of the McCarran Act simply because it benefits policyholders either directly, or indirectly by strengthening the financial condition of the insurer.

Defendants allege that the contractual arrangements between Blue Shield and Participating Pharmacies require nothing more than the performance of obligations owed to Blue Shield's insureds under the drug insurance policies. In concluding that "[t]he Pharmacy Agreement directly pertains to the relationship between Blue Shield and its insureds" the district court held that the Pharmacy Agreement "is simply the performance of the insurer's obligations owed to its insureds under the insurance contract and nothing more." Despite these characterizations of the contractual arrangement, we find that the agreements between Blue Shield and Participating Pharmacies do not require Blue Shield to fix prices or to produce other anticompetitive effects in the pharmaceutical industry. Blue Shield's sole obligation is to see that the insured receives prescription drugs and "shall be required to pay no more than the drug deductible for each of such covered drugs." It is unnecessary for Blue Shield to agree with pharmacies to fix retail sales prices in the pharmaceutical industry. Blue Shield's policyholders are

basically unconcerned with the contract between the insurer and the Participating Pharmacy. They are obligated to pay a Participating Pharmacy two dollars ($2.00) for a prescription regardless of the presence or absence of a price fixing arrangement. Thus, by minimizing costs and maximizing profits, the Participating Pharmacy Agreements inure principally to the benefit of Blue Shield.

The plaintiffs attempt to illustrate by example that the relationship primarily affected by the Pharmacy Agreement and the alleged coercion is that between competing pharmacies and not the relationship between insurer and insured. If the challenged activities in this case are held to constitute the business of insurance, they contend, then automobile insurers will be able to utilize Participating Repair Shop Agreements and coercion to fix prices for parts and labor in the automobile industry. Similarly, they contend that fire insurance companies would be able to execute Participating Construction Company Agreements and thereby combine and conspire with large construction companies to set prices for the repair and rebuilding of homes or buildings damaged by fire. The plaintiffs contend that Congress never intended that the McCarran Act be utilized to shield such activities from application of the federal antitrust laws. They note that Congress, in enacting the McCarran Act, may have condoned state supervised rate setting, but Congress was opposed to private price fixing and did not intend that such activity be shielded from federal scrutiny.

The defendants argue that the Pharmacy Agreement is so inextricably intertwined with the policies that it would be impossible for Blue Shield to fulfill its contractural obligations to its insureds in the absence of such agreements with the pharmacies. The defendants also dispute plaintiffs' arguments that if Blue Shield's activities are permitted, automobile insurers will utilize Participating Repair Shops and fire insurance carriers will enter into

Participating Construction Company Agreements. The defendants contend that the types of insurance referred to by the plaintiffs are not at issue here and such types of insurance are regulated by the provisions of the Texas Insurance Code which are not similar to the ones involved in this case. They also contend that Blue Shield was statutorily required to submit the policies to the state board prior to issuance or use and that the Commissioner authorized the use of the policy and Pharmacy Agreement. Finally, they contend that the activities suggested in the hypothetical examples would require careful examination of the existing laws and regulatory devices relating to automobile insurance and fire insurance. In short, they contend that these hypotheticals are nothing more than speculation and conjecture.

We conclude that Blue Shield is no more obligated to fix the retail prices of pharmaceuticals than an automobile insurer is obligated to its insureds having deductible policies to fix the prices charged for parts and labor. Just as the automobile insurer is obligated to pay the cost of repair, whatever it might be, over and above the applicable policy deductible, Blue Shield is obligated to pay the cost of prescription drugs over and above the two dollar ($2.00) drug deductible. Even though an automobile insurer might be able to guarantee by contract that repairs are done for its customers on a "cost" basis, thereby achieving increased profits or reduced rates, such agreements do not thereby become immune from antitrust scrutiny. *Contra, Proctor v. State Farm Mutual Insurance Co.*, 406 F.Supp. 27 (D.D.C.1975).

The plaintiffs next contend that the Pharmacy Agreement produces results far beyond the simple performance of Blue Shield's responsibilities owed to its insureds under The Prescription Drug Insurance Policy. Blue Shield itself may have recognized that the Pharmacy Agreement goes beyond its obligations under the prescription plan.

The plaintiffs introduced into evidence a letter between two Blue Shield executives which indicated a concern over antitrust problems and suggested that the company camouflage the price fixing arrangement as a "mass accounting agreement." The evidence introduced in the trial court stated as follows: "I think it would be best to draft the contract so that the Insurance Board would require filing of the mass accounting agreement [Pharmacy Agreement] to strengthen your base on anti-trust. Drafting problems will get sticky here, but let's pass on that for now." The plaintiffs contend that this letter carries the Blue Shield plan far beyond the protection of the McCarran Act. They contend that Congress did not contemplate or intend that the McCarran Act should shield from antitrust scrutiny any insurance company's efforts to control the magnitude of its policyholder's claims through the elimination of price and other forms of competition in the industries providing goods and services covered by the insurance policy. Since these activities are not regulated by the State, they contend that the McCarran Act exemption does not apply.

We find that the Pharmacy Agreement goes beyond Blue Shield's obligation as an insurer and places the firm in the business of providing products and services. Blue Shield has agreed to provide protection against the risk that a policyholder will require pharmaceuticals. In order to meet that obligation, Blue Shield is not required to guarantee the provision of services on a "cost-plus" basis or any other basis which might be more economical than the retail purchase of such products. That Blue Shield may wish to protect itself and its customers from rising costs in the pharmaceutical industry does not transform the Pharmacy Agreement into the business of insurance. In fact, the best way for the firm to protect itself from rising costs is to establish and periodically adjust its rate structure to reflect the impact of inflation. Such measures, which are by no means foreign to the insurance business,

involve far less intrusion into the pharmaceutical industry and, consequently, avert the potentially anticompetitive effects alleged here.

The plaintiffs next attempt to come to grips with *Travelers Insurance Company v. Blue Cross,* 481 E.2d 80 (3rd Cir.), *cert. denied,* 414 U.S. 1093, 94 S.Ct. 724, 38 L.Ed.2d 550 (1973), by arguing that the McCarran Act does not apply *ipso facto* to every direct contractual relationship between an insurance company and a provider of benefits. In *Travelers,* the Third Circuit held that the contractual arrangements consummated between Blue Cross and various hospitals for the furnishing of services under insurance policies constituted the business of insurance and, thus, the relationship fell within the McCarran Act exemption. There, as here, the relationship was a direct contractual relationship the result of which was the performance of obligations owed to the insured by the insurer on an economically favorable basis. The plaintiffs have attempted to distinguish *Travelers* by arguing that the Third Circuit was merely approving the actions of the Insurance Commissioner of Pennsylvania who was exerting pressure on the large insurance companies to exercise their power over hospitals to reduce hospital costs. This interpretation, with which we agree was adopted in *Doctors, Inc. v. Blue Cross,* 431 F.Supp. 5 (E.D.Pa. 1975), *aff'd per curiam,* 557 F.2d 1001 (3d Cir. 1976).[5] Moreover,

[5] The court indicated the narrow scope of *Travelers* as follows:

> It is therefore readily apparent from the reading of the *Travelers* case that the Third Circuit is approving the *actions of the Insurance Commissioner of Pennsylvania when he exerts pressure* on the large insurance companies to get them to exercise their power over hospitals to force the hospitals to cut costs wherever possible. This is exactly what Blue Cross was doing in our case at the bequest of the Insurance Commissioner. Therefore, since the McCarran-Ferguson exemption was applicable in Travelers . . ., I hold today that the McCarran-Ferguson exemption is applicable in *Doctors, Inc.* . . . *Doctors, Inc. vs. Blue Cross,* 431 F.Supp. 5, 10 (E.D.Pa.1975), *aff'd* 557 F.2d 1001 (3d Cir. 1976) (emphasis added).

the *Travelers* decision was based in large measure on the Pennsylvania legislature's control over rates charged by non-profit hospitals. That regulation was undertaken pursuant to a statutorily created interrelationship between the rates charged by nonprofit health insurers and nonprofit hospitals, which interrelationship was to be regulated by the Pennsylvania Insurance Department. The plaintiffs note that the Texas Legislature has not chosen indirectly or directly to control the rates charged by pharmacies either by directing and controlling contracts between insurers and pharmacies or by creating an interrelationship between the rates charged by pharmacies and those charged by insurers. Since *Travelers* held simply that the contract between a nonprofit health insurer and a nonprofit hospital was shielded by the McCarran Act from attack, *Travelers* carries little precedential value in this appeal.

Rather, the instant case is more nearly akin to *Battle v. Liberty Nat'l Life Ins. Co.,* 493 F.2d 39 (5th Cir. 1974), *cert. denied,* 419 U.S. 1110, 95 S.Ct. 784, 42 L.Ed.2d 807 (1975). In *Battle* several funeral homes and directors brought suit against an insurer, which issued burial policies, and the insurer's wholly owned subsidiary which supplied merchandise and services required by the insurer's policies. Although this court found coercion with respect to the insurer's discrimination in benefits, the court felt that the facts were inadequately developed to make a conclusive determination on the McCarran Act issue. Nonetheless, the court stated as follows: "[I]t might be plausibly argued that these facts do not constitute the business of insurance as contemplated by the McCarran Act and thus do not fall

within its exemption.''[6] The court noted that the obligations under the insurer's arrangement might be related to the business of insurance, but the obligations were so remotely related as to be subject to the antitrust laws. Relying on *Battle,* the plaintiffs argue that the defendants' activities challenged herein are not peculiar to the insurance industry and are not the business of insurance. They argue that by providing markedly decreased benefits to those subscribers who patronize a nonparticipating pharmacy, Blue Shield intentionally and overtly coerces its subscribers to boycott these pharmacies. Not only does this boycott operate to coerce the nonsigning pharmacies to participate in the plan, it also forecloses nonsigning pharmacies from a significant portion of the market and secures for participating pharmacies the sales of prescription drugs required by Blue Shield's claimants. Since this activity is not peculiar to the insurance industry, plaintiffs argue that it does not constitute the business of insurance. As in *Battle*, the contractual agreements here under review are somewhat related to the business of insurance. The relationship, however, is so attenuated that it must be subject to the antitrust laws. As the plaintiffs have so well articulated, ''it is not the office of the insurance industry to set the prices in the various sectors of our economy so that insurers will enjoy an added measure of control over the magnitude of individual claims.''

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[6] The Court stated:

> It appears that, since the insurance contract confers far more benefits upon the policyholder if he uses an authorized funeral home, the policyholder is subtly coerced into dealing only with the authorized home. The imposition of this restraint would effectively foreclose the unauthorized funeral director's access to a substantial portion of the market. 493 F.2d at 44-45.

The court held that these facts ''if established, would tend to support a finding of unreasonable restraint of trade.''

493 F.2d at 44.

The plaintiffs next take issue with the finding of the district court that a 1962 Opinion of the Texas Attorney General has concluded that the challenged activity constitutes the business of insurance. The court read the 1962 Opinion as a determination by the Texas Attorney General that a plan ''substantially similar'' to Blue Shield's plan constituted the business of insurance. Plaintiffs contend that the Attorney General's Opinion held only that the particular firm in question was an insurance company and not that a program substantially similar to Blue Shield's constituted the business of insurance. The plaintiffs allege that the Attorney General's Opinion was based strictly on the facts presented and that it bears no logical relevance to the question whether the activities challenged in this suit constitute the business of insurance. Although the 1962 opinion is not without ambiguity, it appears to focus on the status of the company itself; it does not conclusively establish whether the State considers a plan such as Blue Shield's Pharmacy Agreement to constitute ''the business of insurance.'' Thus, we are compelled to eschew the heavy weight usually given a state's determination that an activity constitutes the ''business of insurance'' in favor of the interpretation given the term by the federal courts. *See SEC v. Variable Annuity Co.,* 359 U.S. 65, 69, 79 S.Ct. 618, 3 L.E.2d 640 (1959).

The State has shed very little light on this matter since the 1962 Attorney General's Opinion discussed above. Although the plaintiffs argue that the State Board of Insurance does not consider The Pharmacy Agreement to encompass or constitute the business of insurance, it is by no means clear that the State has even considered the question. The district court concluded that ''[t]he State of Texas has actively regulated the activities challenged in plaintiff's complaint since the inception of Blue Shield's Prescription Drug Insurance Program.'' (emphasis added). Plaintiffs contend that the State uses the word ''program'' loosely in that the Board of Insurance approved nothing more than

the insurance policy itself and it did not consider the Pharmacy Agreement, which is at issue in this case.

It is clear from the record that the Board has never approved the Pharmacy Agreement, and the Division Manager of the Board's Policy Approval Division, a Mr. Pogue, testified that he thought the Pharmacy Agreement was outside of the State's regulatory control. He stated as follows: "I do not feel that a contract of that nature falls within the jurisdiction of the State Board of Insurance." Plaintiffs argue that the Pharmacy Agreement does not fall within the jurisdiction of the State Board of Insurance simply because it does not constitute the business of insurance.

There is some testimony which contradicts the testimony of Mr. Pogue. A former employee of the State Board of Insurance, a Mr. Connor, gave an arguably contradictory response to what the plaintiffs describe as a "convoluted question" concerning the exemption of Blue Shield's Prescription Drug Insurance Policy form. With respect to this exemption, the following exchange took place between counsel for Blue Shield and Mr. Connor:

> Q. [By Mr. Kaiser] . . . Mr. Connor, at the time of the issuance of this Exemption Order that you are looking at right now, was it your opinion that this particular contract which is marked Deposition Exhibit 52 [the Prescription Drug Insurance Policy], along with the Participating Drug Pharmacy Agreement which Blue Shield proposed to issue, was it your opinion *that that* constituted the business of insurance?
>
> A. [Mr. Connor] Yes.

Plaintiff concedes that one might draw from this exchange that Connor though the Pharmacy Agreement was a part of the business of insurance. Plaintiffs argue, however, that the phrase "that that" leaves the issue in doubt because Connor may have understood the phrase "that that" to refer only to the policy itself and not to the Pharmacy

Agreement. This position is bolstered by Connor's earlier testimony, wherein he stated that he did not recall having occasion to review the Pharmacy Agreement before drafting the Exemption Order and that he had "no recollection of receiving the document."

The testimony of these officials, therefore, at best raises a factual issue concerning the State's position. It, like the 1962 Attorney General's Opinion, is not a definitive statement of the State's position.

The defendants nonetheless place great emphasis on the extent of state regulation and attempt to minimize plaintiffs' arguments concerning the "business of insurance." They rely on *Crawford v. American Title Ins. Co.*, 518 F.2d 217 (5th Cir. 1975), where this court held that pervasive regulation by the State of Alabama over antitrust matters in the insurance industry precluded application of the federal antitrust laws. The problem with the defendants' position is that the McCarran Act applies only when the activity concerned is the business of insurance *and* the activity is regulated by the State. In *Crawford* there was no question that the challenged conduct constituted the business of insurance; rather, the issue was the extent and pervasiveness of state regulation. There seems to be no question that the State of Texas regulates the insurance industry quite vigorously, but there is no similar indication that the activities complained of are considered the business of insurance by the State or by any common sense interpretation of that term.[7]

We recognize that several district courts have rendered decisions contrary to the conclusion we reach today. *Mana-*

---

[7] The McCarran Act likewise affords no antitrust exemption to the so-called noninsurance company defendants who are parties to this litigation. Indeed, it would be highly anomalous for this court to conclude that the sale of pharmaceuticals by these defendants constitutes the "business of insurance" for purposes of federal antitrust law.

sen v. *California Dental Services,* 424 F.Supp. 657 (N.D.Cal. 1976); *Proctor v. State Farm Mutual Insurance Co.,* 406 F.Supp. 27 (D.D.C. 1975); *Schwartz v. Commonwealth Land Title Insurance Co.,* 374 F.Supp. 564 (E.D.Pa.1974), subsequent proceedings reported at 384 F.Supp. 302 (E.D.Pa. 1974); *Nankin Hospital v. Michigan Hospital Service,* 361 F.Supp. 1199 (E.D.Mich.1973); *California League of Independent Insurance Producers v. Aetna Casualty & Surety Co*, 175 F.Supp. 857 (N.D.Cal. 1969). Indeed, two such cases have been affirmed on appeal. *Anderson v. Medical Service of the District of Columbia,* 551 F.2d 304 (4th Cir. 1977); *Frankford Hospital v. Blue Cross,* 554 F.2d 1253 (3d Cir. May 2, 1977). Perhaps the most far-reaching of these is the *Manasen* case, in which the district court concluded that the McCarran Act exemption applied to a nonprofit corporation engaged in the administration and operation of prepaid dental care programs. The defendant corporation administered prepaid dental care plans under agreements and contracts with various subscriber groups and subscribing purchasers, including governmental bodies, employer organizations, and joint employer-labor trust funds. The subscribers paid periodic premiums to CDS in exchange for future dental services performed for individuals on whose behalf the premiums were paid.

Professional services were performed by practicing dentists who were classified by CDS as "participating" or "nonparticipating" dentists. In order to attain the "participating" status, a dentist was required to look solely to CDS for payment and to set patients' fees at levels not in excess of the amounts established in a CDS approved fee schedule. Any dentist who did not agree to limit his fees to the range specified by CDS would be classified by the corporation as "nonparticipating." Covered patients who selected participating dentists to perform services would receive full benefits under the program. Patients seeking care from nonparticipating dentists, however, would receive less

than the full benefits from CDS. The plaintiffs alleged that this arrangement had the effect of excluding nonparticipating dentists from the CDS market since a CDS patient who sought services from a nonparticipating dentist suffered a financial detriment. Although the defendant corporation was not an insurance company, the court concluded that it was engaged in the business of insurance for McCarran Act purposes. The court placed considerable weight on the favorable impact of the arrangement on the company's insurance rates:

> It is undisputed that the level of dentists' fees are a major factor in determining policy premiums. CDS' payment arrangements to service providers are critical elements in CDS' contractual agreements with its subscribers. These arrangements are intimately related to the interpretation and implementation of CDS' policies and to its reliability as an insurer. Accordingly, the Court finds that the activities challenged in the instant complaint constitute part of the "business of insurance" within the meaning of the McCarran Act.

424 F.Supp. at 666-67 (footnote omitted).

We find ourselves in serious disagreement with the rationale underlying the *Manasen* decision. An activity is not a part of the business of insurance solely because it has an impact, favorable or otherwise, upon premiums charged by the insurer. Monopolistic or coercive activities in "provider industries" may often have a favorable economic impact upon the rates or the costs of insurance companies. But such practices do not become clothed with McCarran Act protection simply because an insurance company has contracted to pay the provider for products or services.

In *SEC v. Nat'l Securities Inc., supra,* the Supreme Court held that the activity of two insurance companies in merging did not constitute the business of insurance, despite the fact that the transaction undoubtedly affected policyholders

in terms of the security of their insurance contracts and the reliability of their insurers. Moreover, business activities of insurance companies not peculiar to the insurance industry are outside the scope of the McCarran Act. *Center Ins. Agency v. Byers,* (N.D.Ill.1976); *American Family Life Assurance Co. v. Planned Marketing Asscciates,* 389 F. Supp. 1141 (E.D.Va.1974); *American General Ins. Co.* v. *FTC,* 359 F.Supp. 887 (S.D.Tex.1973), *aff'd* 496 F.2d 197 (5th Cir. 1974). As indicated by the activities of the noninsurance company in *Manasen, supra,* the activity complained of by plaintiffs is not peculiar to the insurance industry. To be sure, price fixing and coercion induced by firms with superior bargaining power are often found in all industries. Thus, Blue Shield's attempts to control costs in the pharmaceutical industry might just as easily be undertaken by a noninsurance firm attempting to meet a contractual obligation to deliver drugs to a wholesale or retail purchaser.

Manasen and other cases have emphasized the favorable impact that price fixing and coercion have had on insurance premiums and the "reliability" of the insurers. It is conceivable that the public might benefit from price fixing arrangements as long as the parties to the arrangement agree to keep prices below free market levels. The Congress, however, has foreseen that the power to fix prices might not always be beneficially administered by those parties holding the power once their competition has been put out of business. It is quite clear that competitors can be destroyed by those whose financial resources permit them to reduce prices until their competition is eliminated, only for the purpose of raising prices in the long run. Whether such economic coercion is proper is not for a court to decide. It is a matter of national policy which has been addressed by the Congress, from which any change will originate only after appropriate investigation, hearings and deliberation. We apply the law as presently determined by the

Congress and we hold that the antitrust laws are applicable to the arrangements challenged herein.

We conclude, therefore, that Blue Shield's Pharmacy Agreement is not a part of the business of insurance and is not shielded from antitrust scrutiny even though it may have some effect upon the company's policyholders and rates.

REVERSED.

APPENDIX C

Judgment of United States Court of Appeals for the Fifth Circuit, August 8, 1977

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

(Caption deleted in printing)

JUDGMENT

This cause came on to be heard on the transcript of the record from the United States District Court for the Western District of Texas, and was argued by counsel;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, reversed;

It is further ordered that defendants-appellees pay to plaintiffs-appellants, the costs on appeal to be taxed by the Clerk of this Court.

August 8, 1977

Issued as Mandate:

APPENDIX D

Notice of Order Denying Petition for Rehearing and Rehearing En Banc, October 27, 1977

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT

OFFICE OF THE CLERK

Tel 504—589-6514

600 Camp Street
New Orleans, La. 70130

Edward W. Wadsworth
Clerk

October 27, 1977

TO ALL PARTIES LISTED BELOW:

No. 76-2746—ROYAL DRUG COMPANY, INC., ETC., ET AL. v. GROUP LIFE AND HEALTH INSURANCE CO., ETC., ET AL.

Dear Counsel:

This is to advise that an order has this day been entered denying the petition( ) for rehearing,* and no member of the panel nor Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Local Fifth Circuit Rule 12) the petition( ) for rehearing en banc has also been denied.

See Rule 41, Federal Rules of Appellate Procedure for issuance and stay of the mandate.

Very truly yours,
EDWARD W. WADSWORTH, *Clerk*
By /s/ BRENDA M. HAUCK
Deputy Clerk

**on behalf of appellees, Group Life and Health Ins. Co.,

APPENDIX E

Relevant Provisions of McCarran-Ferguson Act

McCarran Act § 1, 15 U.S.C. § 1011:

Declaration of Policy.

Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation of taxation of such business by the several States.

McCarran Act § 2, 15 U.S.C. § 1012:

Regulation by State Law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948.

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided,* That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act cf Setember 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

McCarran Act § 3(b), 15 U.S.C. § 1013(b):

Suspension until June 30, 1948, of application of certain Federal laws; Sherman Anti-Trust Act applicable to agreements to, or acts of, boycott, coercion, or intimidation.

• • •

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

JAN 19 1978

In The

Supreme Court of the United States

October Term, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, et al.,

Petitioners,

vs.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and CHECO PRESCRIPTION PHARMACY, et al.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

MOTION FOR LEAVE TO FILE AND AMICUS CURIAE BRIEF OF BLUE SHIELD ASSOCIATION IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

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GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, et al.,

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Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF OF BLUE SHIELD ASSOCIATION

Blue Shield Association ("BSA"), a nonprofit association of sixty-nine nonprofit medical prepayment plans located throughout the United States, hereby moves this Court pursuant to Rule 42(3) for leave to file the

attached brief *amicus curiae* in support of the petition for a writ of certiorari of petitioners Group Life and Health Insurance Company (Blue Shield of Texas), Reiger/Medi-Save Pharmacies, Inc., Walgreen Texas Co., and The Sommers Drug Stores Co. BSA has been refused permission to file an *amicus curiae* brief by the respondents.

I.
THE INTEREST OF BLUE SHIELD ASSOCIATION

More than 85 million persons in the United States were served by the sixty-nine Blue Shield Plans* in both private and government business during 1976. In 1976 alone, Blue Shield Plans paid out more than $8 billion in medical benefits for their subscribers. All Blue Shield Plans are nonprofit and belong to the Blue Shield Association, a nonprofit organization which, among other things, administers the various Membership Standards relating to containment of health care costs and other matters.

More than seven million subscribers of Blue Shield and Blue Cross Plans nationwide have coverage under out-of-hospital prescription drug insurance programs which contain provisions similar to those challenged in this case. The Plans processed more than thirty million claims and paid out over $165 million in benefits under these programs during 1976. A substantial proportion of the claims and benefits were covered as a result of a collective bargaining agreement between the United Automobile Workers and the domestic automobile manufacturers; forty-two Plans process claims under the automobile industry program.

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* Appendix A to the attached brief lists the sixty-nine Blue Shield Plans in the United States.

The Blue Shield Plans which underwrite prescription drug insurance programs similar in relevant respects to the program involved in this suit are directly affected by the Fifth Circuit holding that an integral element of these programs is not part of "the business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* (1970).

II.
RELEVANT ISSUES WHICH MAY NOT ADEQUATELY BE PRESENTED BY THE PARTIES

The parties to this petition may not afford this Court an opportunity to consider the nationwide impact of the Fifth Circuit's decision on the seven million subscribers of nonprofit out-of-hospital prescription drug programs offered by the Plans. Pharmacy agreements like those specifically held not to be part of "the business of insurance" are an integral aspect of BSA's cost containment efforts. Such agreements do not, contrary to the Fifth Circuit's decision below, fix the retail prices at which prescription drugs are sold. Moreover, the Court of Appeals' interpretation of these programs is inconsistent with the position taken by the Department of Justice.

CONCLUSION

In short, the Fifth Circuit's decision may affect a fundamental aspect of Blue Shield's cost containment efforts involving prescription drug programs. BSA respectfully requests this Court for leave to file the attached *amicus curiae* brief in support of the petitioners.

Respectfully submitted,

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IN THE

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OCTOBER TERM, 1977

No. 77-952

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AMICUS CURIAE BRIEF OF THE BLUE SHIELD ASSOCIATION

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Blue Shield Association submits this brief as *amicus curiae* in support of the petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit.

THE INTEREST OF THE AMICUS CURIAE

The interest of the Blue Shield Association is set forth in the accompanying Motion for Leave to File This Brief.

REASONS FOR GRANTING THE WRIT

The provision for reimbursement in the prescription drug program challenged in this case is an essential means of minimizing costs. Under the program, the out-of-pocket cost to the subscriber usually is less if the prescription is filled at a participating pharmacy. Therefore, subscribers have an incentive to patronize pharmacies which have agreed (1) to charge the subscriber no more than the deductible fee applicable to the program, and (2) to accept reimbursement from the Plan in the amount of the acquisition cost of the drug plus a dispensing fee. This reimbursement mechanism helps minimize cost for two reasons. First, it is less expensive for the Plan to process claims filed by participating pharmacies. Further, it is easier for the Plan to predict the cost of fulfilling its obligations.

The basis for reimbursing participating pharmacies, including the amount of the dispensing fee, is determined unilaterally by each Plan. Each pharmacy makes

an individual decision to participate, or not, according to its own assessment of the advantages and disadvantages.

More than thirty-two thousand pharmacists have signed participating agreements similar to the agreements challenged by the plaintiffs in this case. The Fifth Circuit decision subjects most, if not all, Plan drug insurance programs containing similar reimbursement provisions to potential antitrust litigation.

I.

THE PHARMACY AGREEMENTS ARE AN INTEGRAL ASPECT OF BLUE SHIELD'S OST CONTAINMENT EFFORTS.

The method of reimbursement is at the root of this case. It has been developed and widely utilized by the Plans in order to provide prescription drug benefits defined in terms of health care needs at the lowest possible cost. The prepayment charge to subscribers is the sum of the cost of the drugs and the administrative cost of processing claims. The reimbursement mechanism enables the Plans to keep both parts of the cost low.

There are two alternative methods of reimbursement under most Plan drug insurance programs. *First*, a subscriber who purchases prescription drugs covered by the policy from a "participating" pharmacy pays the pharmacy, at most, a specified deductible ranging up to $3.00, depending on the agreement. The pharmacy then files a claim for reimbursement directly from the Plan. The total amount received by a participating pharmacy for the drug has three components: the deductible, the acquisition cost of the drug, and the dispensing fee. In addition to the deductible, received directly from the subscriber, the pharmacy is reimbursed by the Plan for the amount of its actual acquisition cost of the drug plus

the dispensing fee, minus the amount of the deductible.* *Second*, a subscriber who purchases drugs from a nonparticipating pharmacy, pays the pharmacy the full prescription price and files his own claim for reimbursement for a specified percentage (commonly 75 percent) of the pharmacy's charge in excess of the applicable deductible.

Normally, the out-of-pocket cost will be less for a subscriber who fills the prescription at a participating pharmacy. The difference in out-of-pocket cost to the subscriber under the two reimbursement methods is in direct proportion to the difference in the cost of processing claims submitted by subscribers and by pharmacies. This reimbursement mechanism is designed to provide an incentive for each subscriber to make an individual choice of pharmacies which minimizes costs.

In order to implement the program, the Plans offer to contract individually with any licensed pharmacy which wishes to participate. The amount of the dispensing fee is set unilaterally by each Plan at a level sufficient to ensure that there will be a sufficient number of participating pharmacies to make the cost saving option easily accessible to subscribers.

The pharmacy agreements are an integral aspect of the prescription drug program's overall cost saving design. The reimbursement provision would be illusory if a Plan did not agree with a sufficient number of pharmacies to make the lower cost reimbursement option available to its subscribers. The entire attempt to minimize costs would be ineffective if the Plan agreed to provide protection for subscribers' prescription drug

* BSA understands that the dispensing fee and the deductible are equal under the Texas program and, thus, by coincidence, the amount of reimbursement by Blue Shield of Texas is equal to the acquisition cost of the drug.

needs without regard to cost, being unable to contract with pharmacies in a manner which would ensure the financial integrity of the program.

II.

THE DECISION BELOW IS BASED ON A MISUNDERSTANDING OF HOW THE PHARMACY AGREEMENTS OPERATE.

Although the Fifth Circuit technically ruled only on the availability of the McCarran-Ferguson Act defense to the plaintiffs' antitrust allegations, the court repeatedly characterized the pharmacy agreements as "price-fixing" agreements which "coerce" pharmacies. The Court of Appeals failed to understand how the program works.

The total amount received by a participating pharmacy for the drug has three components: the deductible, the acquisition cost of the drug, and the dispensing fee. The first two of these three components are variable, as follows:

(i) First, a participating pharmacy may charge the subscriber directly for an amount equal to the deductible, but it is also free to discount this deductible or to charge the subscriber nothing.*

(ii) Second, the price the pharmacist pays for the drug, the acquisition cost, varies with the market price and is not influenced by the Plan or the participating pharmacy agreements.

(iii) The third component, the dispensing fee, is merely a unilateral offer from the Plan to each pharmacy.

---

* BSA understands that pharmacies participating in the Texas program may discount the deductible, if they so desire.

Thus, the only component of the "price" which is uniform under the pharmacy agreements is the amount of the dispensing fee, which each Plan unilaterally offers to every pharmacy. Each Plan, like any buyer, must consider the relevant market conditions in making this offer. Each pharmacy, like any seller, must assess relevant market conditions in deciding whether to accept or reject this offer. The program reflects, therefore, a competitive market.

III.

THE FIFTH CIRCUIT'S INTERPRETATION OF THE PROGRAM IS INCONSISTENT WITH THE POSITION TAKEN BY THE DEPARTMENT OF JUSTICE.

The Antitrust Division of the Department of Justice recognized that the unilateral determination by a Blue Shield or Blue Cross Plan of the basis for determining reimbursement, including the amount of the dispensing fee, did not constitute an agreement to fix retail prices. In the latter part of 1967, the Department of Justice, following its Business Review Procedure, reviewed a prescription drug program proposed by the Kansas Physicians Service (Kansas Blue Shield) which contained a similar reimbursement provision and provided for participating pharmacy agreements like the ones challenged in this case. (Appendix B hereto.) The Department of Justice advised the Kansas Plan in January, 1968 that it did not intend "to initiate any proceedings under the federal antitrust laws to prevent placing the plan into effect." After that a number of Plans initiated similar programs. (Appendix C hereto.) None have been challenged by the Department of Justice. The Department of Justice's position is in marked contrast to the Fifth Circuit's decision below.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

JAMES W. RANKIN
ROGER G. WILSON
MILDRED B. LEVY
KIRKLAND & ELLIS
200 East Randolph Drive
Chicago, Illinois 60601
(312) 861-2000

Attorneys for
Blue Shield Association

APPENDIX

APPENDIX A

BLUE SHIELD PLANS IN THE UNITED STATES

Blue Shield Plans are located throughout the United States. The Plans' principal offices are located in the following cities:

Birmingham, Ala.
Phoenix, Ariz.
Little Rock, Ark.
San Francisco, Calif.
Denver, Colo.
New Haven, Conn.
Wilmington, Del.
Washington, D.C.
Jacksonville, Fla.
Atlanta, Ga.
Columbus, Ga.
Honolulu, Hawaii
Lewiston, Idaho
Chicago, Ill.
Indianapolis, Ind.
Des Moines, Iowa
Topeka, Kansas
Louisville, Ky.
Portland, Maine
Baltimore, Md.
Boston, Mass.
Detroit, Mich.
St. Paul, Minn.
Jackson, Miss.
Kansas City, Mo.
St. Louis, Mo.
Helena, Mont.
Omaha, Neb.
Reno, Nev.
Concord, N.H.
Newark, N.J.
Albuquerque, N.M.
Albany, N.Y.
Buffalo, N.Y.
Jamestown, N.Y.
New York, N.Y.
Rochester, N.Y.
Syracuse, N.Y.
Utica, N.Y.
Durham, N.C.
Fargo, N.D.
Cleveland, Ohio
Worthington, Ohio
Tulsa, Okla.
Portland, Ore.
Camp Hill, Pa.
Providence, R.I.
Columbia, S.C.
Sioux Falls, S.D.
Chattanooga, Tenn.
Memphis, Tenn.
Dallas, Texas
Salt Lake City, Utah
Richmond, Va.
Roanoke, Va.
Bremerton, Wash.
Seattle (King), Wash.
Seattle (WPS), Wash.
Spokane, Wash.
Tacoma, Wash.
Wenatchee, Wash.
Charleston, W. Va.
Clarksburg, W. Va.
Morgantown, W. Va.
Parkersburg, W. Va.
Wheeling, W. Va.
Madison, Wis.
Milwaukee, Wis.
Cheyenne, Wyo.

APPENDIX B

Application by Kansas Physicians' Service, a nonprofit corporation, commonly known as Kansas Blue Shield—Business Review Procedure—proposed prepaid prescription drug prepayment plan, August 30, 1967:

(Letterhead Of)

GOODELL, CASEY, BRIMAN,
RICE & COGSWELL

August 30, 1967

Assistant Attorney General's Office
Antitrust Division
Department of Justice
Washington, D. C. 20530

Gentlemen:

In re: Application by Kansas Physicians' Service, a non-profit corporation, commonly known as Kansas Blue Shield—Business Review Procedure—proposed prepaid prescription drug prepayment plan

We are the attorneys for Kansas Physicians' Service, commonly known as Kansas Blue Shield. Please consider this letter as the application of our client for a review of a proposed Blue Shield prescription drug prepayment program, under your Business Review Procedure for an advance clearance as to whether or not your Department will waive its right to institute criminal proceedings under the antitrust laws.

I am enclosing, herewith, the following documents:

(1) Proposed Agreement to be issued by Kansas Blue Shield to its subscribers providing prescription medications coverage and designated as "Full Pay Plan."

(2) Proposed Agreement to be issued by Kansas Blue Shield to its subscribers providing prescription medications coverage and designated as "Shared Pay Plan."

(3) Proposed Agreement to be executed by Kansas Blue Shield and individual Pharmacists who elect to become a participating pharmacy under the prepaid drug plan.

The above documents are all operative documents proposed for issuance by Blue Shield to implement the plan. Kansas Physicians' Service, commonly known as Kansas Blue Shield, is a non-profit corporation, incorporated under the provisions of the non-profit Medical Service Corporation Act of Kansas. I am enclosing, herewith, a copy of the non-profit Medical Service Corporations Act of Kansas for your review and assistance in determining the matter. I am also enclosing one copy of an Opinion issued by the Attorney General of Kansas, dated April 21, 1965, holding that Kansas Physicians' Service has the authority to issue Dental coverage plans under the provisions of K.S.A. 40-1902, which reads in part as follows:

> "Such corporations heretofore or hereafter organized may also provide service or indemnity for *other health services* but not to exceed reasonable and customary charges that a subscriber may incur for these services." (emphasis added)

Kansas Blue Shield proposes to issue the prepaid drug plan under the authority of the above quoted section which allows the issuance of such plan "for other health services."

In general, the proposed drug prepayment plan will be issued to citizens of the State of Kansas who elect to pay the premium determined by Kansas Blue Cross-Blue Shield to be necessary to allow this coverage. A subscriber may elect to have any prescription filled at any pharmacy of his choice. In the event that the subscriber has coverage under the "Full Pay Plan," eligible prescriptions will be filled by either a participating or a non-participating Phar-

macist selected by the subscriber. In the event that the Pharmacist is a participating Pharmacist, the subscriber will provide proof of coverage under this agreement, to the Pharmacist. The participating Pharmacist will then, under the terms of his agreement with Kansas Blue Shield, receive from Kansas Blue Shield an amount equal to the Pharmacist's actual acquisition cost of the prescription medication (as defined in the policy) and a dispensing fee of $2.00. In the event that the subscriber elects to have the prescription filled at a non-participating pharmacy, the subscriber will pay the amount direct to the Pharmacist and then make a claim to Blue Shield. Kansas Blue Shield will provide an indemnity of an amount not to exceed 75% of the usual and customary charge of the Pharmacy, or 75% of the amount a participating pharmacy would have charged for the same prescription, whichever is the lesser.

The procedure for the proposed "Shared Pay Plan" in general is identical except for the amount to be paid by Kansas Blue Shield. In the "Shared Pay Plan" the participating pharmacist will charge the subscriber 50% and Blue Shield will pay to the participating pharmacist the remaining 50% of the charge for the prescription. Under the "Shared Pay Plan," the subscriber will pay the full charge of the non-participating pharmacist, and the subscriber will be entitled to an indemnity of an amount not to exceed 50% of 75% of the usual and customary charges of the non-participating pharmacist, or 50% of 75% of the amount paid to a participating pharmacy for the same prescription, whichever is lesser.

In general, the above summarizes the proposed plan of business conduct maintained by Kansas Physicians' Service. In the event that you need any additional information or documents, please advise and the same will be furnished immediately.

If possible, we hope that your office can review the proposed plan and issue an opinion under the Business Review Procedure at the earliest possible time, hopefully by September 15, 1967. If it is not possible to secure an opinion by that date, we would appreciate receiving your best estimate as to the time required.

Very truly yours,
/s/ Gerald L. Goodell
Of Goodell, Casey, Briman, Rice & Cogswell

GLG:mh
Encs.
cc Blue Cross-Blue Shield

FULL PAY PLAN

Kansas Blue Shield

PRESCRIPTION MEDICATIONS RIDER

Out-Of-Hospital Only

ARTICLE I. GENERAL PROVISIONS

A. This is a Rider to a Contract or Certificate issued by Kansas Physicians' Service, Topeka, Kansas, a non-profit corporation known as Kansas Blue Shield. The appropriate terms and provisions of the Kansas Blue Shield Contract or Certificate to which this Rider is attached apply except as otherwise specified in this Rider.

B. This Rider is issued for attachment to the Kansas Blue Shield Contract or Certificate and becomes effective for the Subscriber on the Benefit Date shown on the Identification Card.

ARTICLE II. DEFINITIONS

The following definitions are added to Article I, Definitions, of the Contract or Certificate:

A. *Prescription Order* is the request for medication issued by a duly licensed physician, dentist, or podiatrist in the authorized course of his professional practice.

B. *Prescription Charges* shall represent the acquisition cost of the drugs or medication actually used in preparation of the prescription pursuant to a Prescription Order plus a dispensing fee.

C. *Acquisition Cost* shall mean the usual and customary pricing basis but in no instance greater than the—

1. Blue Book Cost, by Manufacturer.
2. Blue Book Cost, by Manufacturer, shall be determined as follows:
   a. Readymade Capsules, Pills, Tablets, and similar Substance—Cost per 100 units.
   b. Readymade Liquids—Cost of 16 ozs.
   c. Readymade ointments and powders dispensed from bulk package—Cost per pound.
   d. Originals—Ear Drops, Eye Drops, Nose Drops, Sprays, and Ointments in tube or jar —Cost of Package.
   e. Injectables—Cost of Ampules—Cost of Vials.
   f. Compounded Prescription—Cost of Ingredient plus 50¢.

D. *Dispensing Fee* means the fixed amount established by the Plan which is paid to the Participating Pharmacy over and above the Acquisition Cost for each Prescription Order or refill dispensed.

E. *Prescription Medications* means drugs or biologicals dispensed for human use pursuant to a Prescription Order which are legend drugs and are thus required, under the Federal Food and Cosmetic Act, to bear the legend: "Caution, Federal law prohibits dispensing without prescription." Excluded are contraceptive medications unless specifically included as an option.

F. *Participating Pharmacy* shall mean any licensed pharmacy which has entered into an agreement with the Plan to provide the pharmaceutical services listed in this Rider.

G. *Non-Participating Provider* shall mean any licensed pharmacy in Kansas which or licensed physician who, has not entered into an agreement with the Plan.

H. *Participating Contract* shall mean the agreement entered into between the Plan and the Participating Pharmacy which shall set forth their respective rights and obligations.

I. *Physician* shall mean a Doctor of Medicine or a Doctor of Osteopathy duly licensed to practice medicine or osteopathy at the time and place the service is provided.

ARTICLE III. RELATIONSHIP BETWEEN SUBSCRIBER AND PARTICIPATING PHARMACY

A. The Agreement between Kansas Blue Shield and the Participating Pharmacy may be terminated by either Kansas Blue Shield or the Participating Pharmacy at any time upon thirty (30) days' prior written notice to the other.

B. It is understood that the Pharmacy need not dispense a Prescription Order for any reason which, in the pharmacist's professional judgment, should not be honored.

ARTICLE IV. ELIGIBLE SERVICES

Charges for Prescription Medications, except for the exclusions indicated in Article V of this Rider, dispensed for use by the Subscriber or any of his eligible Dependents when the Prescription Order is requested by a licensed physician, dentist, or podiatrist in the authorized course of his professional practice.

A. Limitations:
   (1) Only drugs and biologicals which are legend drugs, and are thus required, under the Federal Food and Cosmetic Act, to bear the legend: "Caution, Federal law prohibits dispensing without prescription."
   (2) Refills will be covered up to one year from the date of the Prescription Order.

(3) The quantity of Prescription Drugs dispensed pursuant to an original Prescription Order shall be limited to a supply of thirty-four (34) consecutive days, except that Prescription Orders for medications whose acquisition cost is not greater than $1.00 shall be limited to 100 unit doses for each prescription.

ARTICLE V. EXCLUSIONS

A. The following exclusions apply to the benefits of this Rider in addition to the exclusions of the basic Contract or Certificate to which this Rider is attached:

1. Prescriptions written by any practitioner other than a duly licensed physician, dentist, or podiatrist in the authorized course of his professional practice.
2. The purchase of products other than drugs or biologicals, such as contraceptive or therapeutic devices, artificial appliances, etc.
3. Administration or injection of Prescription Medications.
4. Non-legend, patent, or proprietary drugs.
5. Contraceptive medications unless specifically included as an option.

B. No duplicating payment will be made under this Rider for Prescription Medications which are provided under any other Rider to the Kansas Blue Shield Contract or Certificate to which this Rider is attached.

ARTICLE VI. BENEFITS PROVIDED

A. Benefits will be available for Subscribers' expenses for Prescription Medications when dispensed by a Participating Pharmacy or by a Non-Participating Provider pursuant to a Prescription Order for the out-of-hospital use by the Subscriber or his Dependent covered under this Rider so long as the same is in effect.

At the discretion of Blue Shield, certain devices may be included if related to the use of the prescribed medication.

B. Participating Pharmacy: A Participating Pharmacy will provide the Prescription Order to the Subscriber and will make no charge to the Subscriber.

C. Non-Participating Provider: The Subscriber shall be entitled to an indemnity of an amount not to exceed 75 percent of the Provider's usual and customary charge, or 75 percent of the amount paid to a Participating Pharmacy for the same prescription, whichever is lesser.

ARTICLE VII. PRODUCT LIABILITY

Blue Shield shall not be responsible for any claims arising out of or through the manufacturing, compounding, dispensing, and use of any Prescription Medications whether covered under this Agreement or not.

ARTICLE VIII. CONDITIONS

The Subscriber's Blue Shield Identification Card shall be presented to the Participating Pharmacy when the Subscriber or Dependent applies for benefits under this Rider. The Subscriber authorizes and directs any Pharmacy or other Provider to furnish and make available to Blue Shield any Prescription Order copies for which benefits shall have been claimed on behalf of himself and enrolled dependents.

KANSAS PHYSICIANS' SERVICE
Topeka, Kansas
President

Attest:
Secretary

Form No. .....
7-14-67 rev.

SHARED PAY PLAN

(First 4 Pages same as Full Pay Plan)

ARTICLE V. EXCLUSIONS (continued)

A. 3. Administration or injection of Prescription Medications.

4. Non-legend, patent, or proprietary drugs.

5. Contraceptive medications unless specifically included as an option.

B. No duplicating payment will be made under this Rider for Prescription Medications which are provided under any other Rider to the Kansas Blue Shield Contract or Certificate to which this Rider is attached.

ARTICLE VI. BENEFITS PROVIDED

A. Benefits will be available for Subscribers' expenses for Prescription Medications when dispensed by a Participating Pharmacy or by a Non-Participating Provider pursuant to a Prescription Order for the out-of-hospital use by the Subscriber or his Dependent covered under this Rider so long as the same is in effect, subject to the shared payment agreement in paragraph D of this section. At the discretion of Blue Shield, certain devices may be included if related to the use of the prescribed medication.

B. Participating Pharmacy: A Participating Pharmacy will provide the Prescription Order to the Subscriber and will make no charge to the Subscriber other than the shared payment amount of fifty percent (50%). Blue Shield will pay to the Participating Pharmacy the remaining fifty percent (50%) of covered Prescription Charges.

C. Non-Participating Provider: The Subscriber shall be entitled to an indemnity of an amount not to exceed fifty percent (50%) of 75 percent of the Provider's usual and customary charges, or fifty percent (50%) of 75 percent of the amount paid to a Participating Pharmacy for the same prescription, whichever is lesser.

D. The Subscriber is responsible for the payment of fifty percent (50%) of the covered Prescription Medication Charges.

ARTICLE VII. PRODUCT LIABILITY

Blue Shield shall not be responsible for any claims arising out of or through the manufacturing, compounding, dispensing, and use of any Prescription Medications whether covered under this Agreement or not.

ARTICLE VIII. CONDITIONS

The Subscriber's Blue Shield Identification Card shall be presented to the Participating Pharmacy when the Subscriber or Dependent applies for benefits under this Rider. The Subscriber authorizes and directs any Pharmacy or other Provider to furnish and make available to Blue Shield any Prescription Order copies for which benefits shall have been claimed on behalf of himself and enrolled dependents.

KANSAS PHYSICIANS' SERVICE
Topeka, Kansas

Attest:
Secretary

President

Form No. .....
7-14-67 rev.

Proposed

BLUE SHIELD CONTRACT WITH
PARTICIPATING PHARMACIES

SECTION I. DEFINITIONS

A. *Plan* means Kansas Physicians' Service, hereinafter known as Kansas Blue Shield.

B. *Subscriber* is the person, or any of his eligible dependents, with whom the Plan has entered into a contract to provide benefits.

C. *Dependent* means the spouse of the Subscriber and each eligible dependent child.

D. *Contract Holder* means any individual or organization which has agreed, on behalf of the Subscriber, to remit to the Plan the rates payable under the Subscriber's agreement.

E. *Prescription Order* is the request for medication issued by a duly licensed physician, dentist, or podiatrist in the authorized course of his professional practice.

F. *Prescription Charges* shall represent the acquisition cost of the drugs or medication actually used in preparation of the prescription pursuant to a Prescription Order plus a dispensing fee.

G. *Acquisition Cost* shall mean the usual and customary pricing basis but in no instance greater than the—

1. Blue Book Cost, by Manufacturer.
2. Blue Book Cost, by Manufacturer, shall be determined as follows:
   a. Readymade Capsules, Pills, Tablets, and similar Substance—Cost per 100 units.
   b. Readymade Liquids—Cost of 16 ozs.
   c. Readymade Ointments and Powders dispensed from Bulk Package—Cost per pound.
   d. Originals—Ear Drops, Eye Drops, Nose Drops, Sprays, and Ointments in tube or jar —Cost of Package.
   e. Injectables—Cost of Ampules—Cost of Vials.
   f. Compounded Prescription—Cost of Ingredient plus 50¢.

H. *Dispensing Fee* means the fixed amount established by the Plan which is paid to the Participating Pharmacy over and above the Acquisition Cost for each Prescription Order or refill dispensed.

I. *Prescription Medications* means drugs or biologicals dispensed for human use pursuant to a Prescription Order which are legend drugs, and are thus required, under the Federal Food and Cosmetic Act, to bear the legend: "Caution, Federal law prohibits dispensing without prescription." Excluded are contraceptive medications unless specifically included as an option. At the discretion of Blue Shield, certain devices may be included if related to the use of the prescribed medication.

J. *Participating Pharmacy* shall mean any licensed pharmacy which has entered into an agreement with the Plan to provide the pharmaceutical services listed in the Subscriber's contract.

K. *Participating Contract* shall mean the agreement entered into between the Plan and the Participating Pharmacy which shall set forth their respective rights and obligations.

SECTION II. GENERAL AGREEMENT OF PARTIES

THIS AGREEMENT, made this ..... day of ....., 19...., by and between Kansas Physicians' Service (hereinafter called 'Blue Shield') and ..... (hereinafter called 'Pharmacy'), doing business as a pharmacy with Pharmacy Permit No. ..... located at .... has a current valid permit issued by the Kansas State Board of Pharmacy. The Pharmacy is conducted as a (partnership), (sole proprietorship), (corporation).

Blue Shield agrees that it will furnish to all eligible Subscribers an Identification Card which the Subscriber must present to the pharmacist before he is required to render services. The Pharmacy agrees to provide to such properly identified Subscribers the Prescription Medications required by their Prescription Orders, which are covered under the Subscriber's Prescription Medication Rider or Contract. Prescription Orders must be

made by a duly licensed physician, dentist, or podiatrist in the authorized course of his practice. The pharmacist need not dispense a Prescription Order which for any reason, in his professional judgment, should not be honored. Prescription Medications covered under the Rider or Contract include only those drugs or biologicals dispensed for human use pursuant to a Prescription Order which are legend drugs, and are thus required, under the Federal Food and Cosmetic Act, to bear the legend: "Caution, Federal law prohibits dispensing without prescription." Excluded are contraceptive medications unless specifically included as an option. Refills shall not be covered after one (1) year from the date of the Prescription Order. The quantity of Prescription Drugs dispensed pursuant to an original Prescription Order shall be limited to a supply of thirty-four (34) consecutive days, except that Prescription Orders for medication whose acquisition cost is not greater than $1.00 shall be limited to 100 unit doses for each prescription.

Blue Shield will have the sole right, subject to the above, to determine the individuals eligible for service by the pharmacist for which he is to be reimbursed. The Pharmacy agrees to furnish Blue Shield, on forms to be provided by Blue Shield, a true and correct statement for the Prescription Medications dispensed, including the patient's name and identifying number, the acquisition cost, the total Prescription Charge, and the amount (if any) payable by the Subscriber pursuant to this Contract, and other pertinent information in accordance with the Participating Pharmacy Manual.

Blue Shield agrees to pay as reasonable compensation for the Pharmacy's services an amount equal to the Pharmacy's usual and customary pricing basis but in no instance greater than the Blue Book Cost, and a Dispensing Fee of Two Dollars ($2.00). The Pharmacy agrees to accept in full for its services the payment described in this paragraph without any charge to the Subscriber except for those Subscribers who select the shared payment plan. In this instance, the Pharmacy shall credit the Subscriber in accordance with the plan selected.

The Pharmacy agrees to allow Blue Shield or its duly authorized agent free access to and to furnish such agent during regular business hours, upon demand, such books, records, and prescription files as may be necessary to perform an audit to insure that Acquisition Costs are as reported on claims. It is understood that all information so furnished shall be held as confidential by Blue Shield. Such audits may be made at any time during the term of this Contract or within one year thereafter.

It is understood that the Pharmacy may enter into agreements with any other prepaid prescription drug program and/or commercial insurance company, whether profit or non-profit.

Blue Shield retains the exclusive right to the name 'Blue Shield' and the Blue Shield symbol together with any distinctive trademark and/or service mark that may hereafter be adopted. The Pharmacy agrees not to advertise to the public that it is a Participating Pharmacy nor to use the names, symbols, or trademarks, or 'Blue Shield' in any advertising without the prior written consent of Blue Shield. Upon termination of this Contract, the Pharmacy will immediately discontinue the use of such names, symbols, or trademarks and immediately return any signs, plaques, insignias, displays, or any other advertising material indicating its participating status.

Blue Shield shall not be responsible for any claims arising out of or through the manufacturing, compounding, dispensing, and use of any Prescription Drugs whether covered under this Contract or not, and the Pharmacy agrees to hold Blue Shield harmless against any such claim or demand.

This Contract may be amended at any time by attaching hereto an amendment properly executed by all parties to this Contract.

This Contract may be terminated by either party on thirty (30) days written notice. However, during the said thirty (30) day period, both parties agree that this Contract and its obligations hereunder shall remain in full force and effect.

Blue Shield, notwithstanding the above, reserves the right to cancel this Contract at any time for any breach of this Contract by the Pharmacy and its participation shall terminate forthwith. This right to immediate cancellation by Blue Shield does not in any way effect its other rights enumerated under this Agreement.

No person, agent, or officer of Blue Shield is authorized to alter or vary the terms hereof, nor to make any representation or inducements relative hereto other than those specifically set forth herein. This Contract represents the complete and total agreement of the parties.

Signed and sealed this ..... day of ....., 19.....

..... KANSAS PHYSICIANS' SERVICE

By ..... By .....

(Title) (Title)

(seal) (seal)

APPENDIX C

Department of Justice Clearance, January 15, 1968:

(Letterhead Of)

DEPARTMENT OF JUSTICE

January 15, 1968

Gerald L. Goodell, Esquire
Goodell, Casey, Briman,
Rice & Cogswell
Columbian Building
Topeka, Kansas 66603

Dear Mr. Goodell:

This responds to your letter request of August 30, 1967 for a clearance by the Department of Justice under the Business Review Procedure for a proposed prepaid prescription drug plan to be offered by the Kansas Physicians Service, a non-profit corporation commonly known as Kansas Blue Shield. A copy of a summary of the Department's Business Review Procedure is attached.

Your August 30, 1967 letter outlining the nature of the proposed plan, your supplemental letter of September 27, 1967, and the attached operative documents which are to be used in carrying out the proposed plan have been reviewed.

We understand from your representations that the prices to be paid participating pharmacists, including the amount of the dispensing fee, have been unilaterally determined by Blue Shield, and that future changes in prices will also be determined unilaterally. In this connection, we understand that the prepaid prescription drug plan does not contemplate inviting any concerted action among the pharmacists, or within any pharmaceutical association, pursuant to which pharmacists would agree upon or jointly act in determining whether to join the plan or in determining

the schedule of drug prices or the amount of the dispensing fees to be paid by Blue Shield.

We also understand that the 25% differential in fees paid non-member pharmacists reflects a reasonable assessment of the additional administrative expenses in processing such claims.

This is to advise that on the basis of the information submitted, the Department does not propose to initiate any proceedings under the federal antitrust laws to prevent placing the plan into effect in the manner outlined in your letters. In view of the novelty of the proposal, we reserve the right to assess its actual operation and to take appropriate action in the event experience under the plan or the manner in which the plan is implemented indicates a violation of the antitrust laws.

Sincerely yours,
/s/ Donald F. Turner
Assistant Attorney General
Antitrust Division

Attachment

Supreme Court, U. S.
FILED
MAY 12 1978
MICHAEL RODAK, JR., CLERK

APPENDIX

IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY,
also known as
BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC.,
doing business as
ROYAL PHARMACY OF CASTLE HILLS
and
DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI FILED JANUARY 3, 1978
CERTIORARI GRANTED FEBRUARY 27, 1978

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RELEVANT DOCKET ENTRIES

COURT OF APPEALS

FILINGS/PROCEEDINGS

Date	
6/25/76	Flg. Duplicate Notice of Appeal and Clerk's Statement of Docket Entries
7/16/76	Flg. Notice of Election [Under] Rule 30(c) [Deferred Appendix]
7/21/76	Flg. Appellants' Designation
8/2/76	Flg. Amended Notice of Appeal, filed in D.C. 6/23/76
8/2/76	Flg. Record on Appeal
8/4/76	Flg. Exhibits to Brief
9/7/76	Flg. Brief for Appellants
9/8/76	Flg. Appellants' Designation
9/24/76	Flg. Appellee's Designation (Group Life)
9/24/76	Flg. Brief for Appellee Group Life and Health Insurance Company
9/24/76	Flg. Brief for Appellee Rieger, *et al.*
10/4/76	Flg. Motion for Leave to File Reply Brief in Excess Pages (Granted, 10/12/76)
10/6/76	Flg. Appellants' Supplemental Designation
10/12/76	Flg. Reply Brief for Appellants
10/26/76	Flg. Motion for Extension of Time to File Appendix
10/27/76	Flg. Exhibits
10/27/76	Flg. Motion for Leave to File Supplemental Record (Granted, 10/27/76)
11/4/76	Flg. Appendix
1/10/77	Flg. Motion of Appellees, Sommers Drug Stores Company, *et al.*, to designate counsel for oral argument

Date	
1/13/77	Flg. Appellants' Letter dated 1/11/77 citing recent decision of the Fourth Circuit Court of Appeals
1/19/77	Flg. Appellee's (Walgreen Texas Co.) Letter dated 1/11/77
1/20/77	Flg. Letter of Appellee Group Life and Health Insurance Company, dated 1/17/77 responding to Appellants' letter dated 1/11/77 and citing recent opinions, copies attached
3/28/77	Flg. Appellants' letter dated 3/24/77 citing recent opinion of the U.S. Court of Appeals for the Fourth Circuit
4/13/77	Flg. Letter of Appellee, Group Life and Health Insurance Company, dated 4/11/77 enclosing recent opinion of the U.S. Court of Appeals for the Fourth Circuit
6/3/77	Flg. Appellants' letter dated 5/30/77 enclosing a copy of opinion in *Barry* v. *St. Paul Fire & Marine Ins. Co.*
6/23/77	Flg. Letter of Appellee, Group Life and Health Insurance Company, dated 6/21/77 enclosing copy of recent decision from U.S. Court of Appeals for the District of Columbia
6/27/77	Flg. Appellants' letter dated 6/27/77 replying to Appellees' letter dated 6/21/77
8/8/77	Opinion Rendered
8/8/77	[Judgment of U.S. Court of Appeals for the Fifth Circuit]
8/22/77	Flg. Petition for Rehearing *En Banc*
9/6/77	Flg. Brief of *Amicus Curiae* (R.B. Cousins) in support of Petition for Rehearing *En Banc*
9/12/77	Flg. *Amicus Curiae* (Allstate Insurance Company)
9/19/77	Flg. Order Granting Motion of Allstate Insurance Company for Leave to File Brief as *Amicus Curiae* in support of Appellees' Petition for Rehearing and Rehearing En Banc and for Extension to file same to 9/19/77

Date	
9/20/77	Flg. Brief of *Amicus Curiae,* Allstate Insurance Company, in support of Petition for Rehearing *En Banc* on behalf of Appellees, Group Life and Health Insurance Company
9/22/77	Flg. Appellees' Supplement to Petition For Rehearing *En Banc*
10/27/77	Order Denying Rehearing *En Banc*
11/3/77	Flg. Motion for Stay of Mandate
11/9/77	Flg. Appellees' Reply to Appellants' Opposition to Appellees' Motion for Stay of Mandate
11/10/77	Flg. Appellants' Supplemental Response to Appellees' Reply to Appellants' Opposition to Motion for Stay of Mandate
11/14/77	[Order Granting Motion for Stay of Mandate]
12/6/77	Flg. Motion for Further Stay of Mandate
12/16/77	[Order Granting Motion for Further Stay of Mandate]

DISTRICT COURT

FILINGS/PROCEEDINGS

Date		
5/29/75	1.	Original Complaint, filed. [J]ury demand
5/30/75		Summonses issued. (4)
6/4/75	2.	Summons (Sommers Drug Stores) re/ex 6-2-75.
6/16/75	3.	Summons (Gibson Pharmacy by serving Sec. of State of Texas) re/ex 6-3-75.
6/20/75	4.	Original Ans. of Deft., Rieger/Medi-Save Pharmacies, Inc., filed.
6/23/75	5.	Marshal's Return on Complaint and Summons re/ex 6/10/75.
6/23/75	6.	Deft. Answer [The Sommers Drug Store Company] and Jury Demand, filed.
6/26/75	7.	Marshal's Return on Complaint & Summons re/ex 6/10/75
6/27/75	8.	Answer of Deft. Group Life & Health Ins. Co., filed.
6/27/75	9.	Request for Production of Documents by Deft. Group Life & Health Insurance Co. (First set), Joel H. Pullen, Attorney for Pltfs., filed.
6/27/75	10.	Answer of Def. Walgreen Texas Co. and Jury Demand, filed.
7/30/75	11.	Agreed Motion for Ext. of Time to Resp. to Deft's Request for Prod. of Doc., filed.
8/7/75	12.	Order Granting Agreed Motion for Ext. of Time To Resp. to Deft's Request for Prod. of Doc., filed.
8/8/75	13.	Order Preliminary to Pre-Trial Conference, filed.
8/11/75	14.	Pltfs' Objections and Ans. to Request for Prod. of Doc., filed.
8/13/75	15.	Pltfs' Motion to Bifurcate Discovery & for Protective Order, filed.

Date		
8/20/75	16.	Opposition of Deft. Group Life & Health Ins. Co. to Pltfs' Motion to Bifurcate Discovery & in the Alternative for Protective Order Pursuant to Rule 26, Fed. Rules of Civil Proc., filed.
8/20/75	17.	Memo Brief of Deft. Group Life & Health Ins. Co. in Opposition to Pltfs' Motion to Bifurcate Discovery & in the Alternative for Protective Order, filed.
8/25/75	18.	Deft., Rieger-Medi-Save, Inc.'s, Response in Opposition to Pltfs' Motion to Bifurcate Discovery & for Alternative Relief, filed.
8/25/75	19.	Brief in Support of Deft., Rieger-Medi-Save, Inc.'s Response in Opposition to Pltfs' Motion to Bifurcate Discovery & for Alternative Relief, filed.
8/25/75	20.	Opposition of Deft., Walgreen Texas Co., to Motion of Pltfs' Motion to Bifurcate Disc. & in the Alternative, for Protective Order, filed.
8/26/75	21.	Response of Deft., the Sommers Drug Stores Co., to Pltfs' Motion to Bifurcate Discovery and in the Alternative for Protective Order, filed.
8/27/75	22.	Brief of Pltfs in Resp. to Defts' Opposition to Pltfs' Motion to Bifurcate Discovery, filed.
8/29/75	23.	Reply of Deft. Group Life & Health Ins. Co. to Brief of Pltfs. in Response to Defts' Opposition to Pltfs' Motion to Bifurcate Discovery, filed.
9/10/75	24.	Notice Duces Tecum to Take Deposition Upon Oral Examination, filed.
9/29/75	25.	Order Denying Pltfs' Motion to Bifurcate Discovery & in the Alternative for Protective Order, filed.
9/29/75	26.	Order Requiring Stipulation of Positions on Disputed Discovery, filed.
11/14/75	27.	Notice of Intent to Take Deposition.
12/3/75	28.	Stipulation of Dismissals. Filed.

Date		
12/12/75	29.	Notice Duces Tecum to take Deposition Upon Oral Examination. Filed. (Mr. A. W. Pogue)
12/12/75	30.	Notice Duces Tecum to take Deposition Upon Oral Examination of Mr. R. C. McAnelly. Filed.
12/12/75	31.	Notice Duces Tecum to take Deposition Upon Oral Examination of Mr. Donald H. Bunnell. Filed.
12/12/75	32.	Notice Duces Tecum to take Deposition Upon Oral Examination of Mr. Paul D. Connor. Filed.
12/15/75	33.	Ordered that the Stipulation of Dismissals is approved and cause is dismissed with prejudice as to Alamo Heights Pharmacy, Inc., Patts Drug, Inc., d/b/a Patt's Drug Store No. 1, Thomas J. Parma d/b/a Parma's Pharmacy, Baylor Parsons d/b/a Parson's Pharmacy, James Pollock d/b/a Pollock's Pharmacy, Physicians & Surgeons Pharmacy, Inc., and Charles Griffin d/b/a Dellview Drug Store.
12/15/75		DOCKET CALL: Pre-Trial Order due April, 1976. Case will be called for announcements and possible setting on March-April Docket.
12/23/75	34.	Amended Notice to take Deposition Upon Oral Examination of Paul D. Connor. Filed.
12/23/75	35.	Amended Notice to take Deposition upon Oral Examination of R. C. McAnelly. Filed.
12/23/75	36.	Amended Notice Duces Tecum to take Deposition Upon Oral Examination of A. W. Pogue. Filed.
12/23/75	37.	Amended Notice Duces Tecum to take Deposition Upon Oral Examination of Donald H. Bunnell. Filed.
12/23/75	38.	Motion to Compel Discovery Filed.
1/6/76		Marshals Return on Deposition Subpoena Received (Re/ex 12/29/75) (A. W. "Woody" Pogue).
1/6/76		Marshals Return on Deposition Subpoena Received (Re/ex 12/29/75) (R. C. McAnelly).

Date		
1/6/76		Marshals Return on Deposition Subpoena Received (Re/ex 12/30/75) (Donald H. Bunnell).
1/6/76		Marshals Return on Deposition Subpoena Received (Re/ex 12/29/75) (Paul D. Connor).
1/6/75	39.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Dellmar Pharmacies, Inc. d/b/a Dellmar Pharmacy #4. Filed.
1/6/76	40.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Dellmar Pharmacies, Inc. d/b/a Dellmar Pharmacy #4. Filed.
1/6/76	41.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Blauser's Pharmacy, Inc. Filed.
1/6/76	42.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Parker's Pharmacy, Inc. Filed.
1/6/76	43.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Highland Hills Pharmacy, Inc. Filed.
1/6/76	44.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Craig Bell d/b/a Bell Pharmacy. Filed.
1/6/76	45.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Royal Drug Co., Inc. d/b/a Pharmacy of Castle Hills and Disco Prescription Pharmacy. Filed.
1/6/76	46.	Notice Duces Tecum to Take Deposition Upon Oral Exam of White Cross Professional Pharmacy, Inc., d/b/a White Cross #1 and #4. Filed.
1/6/76	47.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Blanco Pharmacy, Inc. Filed.
1/6/76	48.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Econodose Systems, Inc. d/b/a Medical Center Pharmacy. Filed.
1/6/76	49.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Gustin Hncir d/b/a Turner's Pharmacists. Filed.

Date		
1/6/76	50.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Carlos Diaz d/b/a Valley View Pharmacy. Filed.
1/6/75	51.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Alfred Sangalli d/b/a Star Drug Store. Filed.
1/6/76	52.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Blanco Southside Pharmacy, Inc. Filed.
1/6/76	53.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Rodolfo L. Davila, Inc. d/b/a Davila Pharmacy. Filed.
1/6/76	54.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Rong, Inc. d/b/a Economy Pharmacy. Filed.
1/6/76	55.	Notice Duces Tecum to Take Deposition Upon Oral Exam of Zarzamora Pharmacy, Inc. Filed.
1/12/76	56.	Notice Int. to Take Depo. Pursuant to Rule 30(b) (6), filed.
1/15/76	57.	Notice of Intention to Take Depos. of Rieger/Medi-Save Pharmacies, filed.
1/15/76	58.	Notice of Intention to Take Depos. of Walgreen Texas Co., filed.
		[no item 59]
1/16/76	60.	Deposition of Donald H. Bunnell, filed.
1/19/76	61.	ORDER Approving Stipulation of Dismissals (Dismissing with prejudice Alamo Hgts. Pharmacy, Inc.; Patts Drug, Inc. dba Patt's Drug Store #1; Thomas J. Parma dba Parma's Pharmacy; Baylor Parson's dba Parson's Pharmacy; James Pollock dba Pollock's Pharmacy; Physicians & Surgeons Pharmacy, Inc; Charles Griffin dba Dellview Drug Store).
1/21/76	62.	Joint Motion to Suspend Discovery and to Modify Order Preliminary to Pre-Trial Conference, filed.

Date		
1/23/76	63.	ORDER Approving Joint Motion to Suspend Discovery and to Modify Order Preliminary to Pre-Trial Conference, filed.
1/28/76	64.	Deposition of Paul D. Connor and A. W. Pogue, filed.
2/2/76	65.	Deposition of Robert C. McAnelly, filed.
2/23/76	66.	Motion of Def., Group Life & Health Ins. Co., to Dismiss, filed.
2/23/76	67.	Brief of Def., Group Life and Health Ins. Co. in Support of Motion to Dismiss, filed.
2/23/76	68.	Motion of Def., Walgreen Texas Co., to Dismiss, filed.
2/23/76	69.	Motion of Def., The Sommers Drug Stores Co., to Dismiss, filed.
2/23/76	70.	Brief of Sommers Drug Stores Co., in Support of Motion to Dismiss, filed.
2/25/76	71.	Def., Rieger/Medi-Save Pharmacies, Inc.'s Motion to Dismiss, filed.
2/25/76	72.	Memorandum Brief in Support of Def., Rieger/Medi-Save Pharmacies, Inc.'s Motion to Dismiss, filed.
3/10/76	73.	Motion to Extend Time for Filing Defs' Response and Brief to Defs' Motion to Dismiss, filed.
3/11/76	74.	Stipulation of Plfs. & Def., Rieger/Medi-Save Pharmacies, Inc., filed.
3/11/76	75.	Stipulation of Plfs. and Def., Sommers Drug Stores Co., filed.
3/12/76	76.	Stipulation of Plfs. and Def., Walgreen Texas Co., filed.
3/15/76		DOCKET CALL: Hearing on Motion to Dismiss requested by Mr. Pullen and set for April 19, 1976 at 2:30 P.M. All briefs are to be filed in advance. Set on June, 1976 Docket. Settlement not possible at this time.

Date		
3/19/76	77.	ORDER Allowing 10 days to Respond after filing of the last of the depositions of Steve G. McDonald, Judith S. Johnson and Lee Helis, filed.
3/24/76	78.	Depositions of Judith S. Johnson, Lee Helis and Steve G. McDonald, filed.
4/5/76	79.	Plaintiffs' Brief in Opposition to Defendants' Motion to Dismiss, filed.
4/15/76	80.	Defendant's Rieger/Medi-Save Pharmacies, Inc., Reply Brief in Support of its Motion to Dismiss, filed.
4/15/78	81.	Reply of Defendant Group Life and Health Ins. Co. to Plaintiffs' Brief in Opposition to Motion to Dismiss, filed.
4/9/76	82.	Affidavit in Support of Defendant Rieger/Medi-Save Pharmacies, Inc.'s Motion to Dismiss, filed.
4/19/76	83.	Reply of Def., The Sommers Drug Stores Co. to Plaintiffs' Brief in Opposition to Motion to Dismiss, filed.
4/19/76	84.	HEARING ON MOTION TO DISMISS: Movant, Group Life Ins., et al, announced ready. Respondent announced ready. Mr. Kaiser asked Court to treat this motion as a Motion for Summary Judgment. Respondent argued against in that in this instance with reference to drugs, Blue Cross & Blue Shield are not in insurance business. Both sides agreed to an Interlocutory Appeal, whether the Court decides for plaintiff or defendant. Mr. Kaiser cited cases he wishes the Court to consider. Mr. Pullen cited the State Board of Insurance does not feel it has the right to regulate pharmacies. Any additional authorities are to be given to the Court by Friday. The Court will take this matter under advisement. Decision on motion will probably be ready in a week.
5/18/76	84.	MEMORANDUM OPINION, filed. (Including Findings of Fact and Conclusions of Law contained therein.)

Date		
5/18/76	85.	ORDER (consistent with the Memo. Opinion and Findings of Fact and Conclusions of Law) rendering judgment for and in behalf of Defts. Group Life and Health Ins. Co., aka/Blue Shield of Texas, Walgreen Texas Co., The Sommers Drug Stores Co. and Rieger/Medi-Save Pharmacies, Inc. with respect to Plaintiffs' Claims under the federal antitrust laws, filed.
6/16/76	86.	Notice of Appeal, filed. Cy. to Court of Appeals for Fifth Circuit.
6/16/76	87.	Bond for Costs on Appeal Secured by Cash Deposit, filed.
6/23/76	88.	Amended Notice of Appeal, filed.
6/23/76	89.	Amended Bond for Costs on Appeal Secured by Cash Deposit, filed.
6/24/76	90.	Designation of Contents of Record on Appeal, filed.
7/2/76	91.	Designation of Deft. Group Life & Health Ins. Co. of Transcript and Additional Parts to be included in the Record on Appeal, filed.
7/9/76	92.	Appellants' Supplemental Designation of Contents of Record on Appeal, filed. Cy. to Court of Appeals.
7/16/76	93.	Transcript of Hearing on Motions to Dismiss of April 19, 1976, filed.
7/26/76		ORIGINAL RECORD ON APPEAL MAILED THIS DATE to Court of Appeals for the Fifth Circuit.
1/7/78	94.	Copy from the Fifth Circuit of Appellees' Motion for Stay of Mandate, filed.
1/7/78	95.	Order from the Fifth Circuit GRANTING Appellees' Motion for Stay of the Issuance of the Mandate pending Petition for Writ of Certiorari, filed.

COMPLAINT, MAY 29, 1975

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

Civil Action No. SA 75 CA 131

ROYAL DRUG COMPANY, INC. d/b/a ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, BLAUSER'S PHARMACY, INC., PARKERS PHARMACY, INC., CHARLES GRIFFIN d/b/a DELLVIEW DRUG STORE, JAMES POLLOCK, d/b/a POLLOCK'S PHARMACY, THOMAS J. PARMA, d/b/a PARMA'S PHARMACY, CRAIG BELL, d/b/a BELL PHARMACY, GEORGE STONE, d/b/a OLMOS PHARMACY, ALAMO HEIGHTS PHARMACY, INC., PATTS DRUG, INC. d/b/a PATT'S DRUG STORE NO. 1, BAYLOR PARSONS d/b/a PARSONS PHARMACY, HIGHLAND HILLS PHARMACY, INC., ECONODOSE SYSTEMS, INC. d/b/a MEDICAL CENTER PHARMACY, GUSTAVE HNCIR, d/b/a TURNERS PHARMACISTS, PHYSICIAN & SURGEONS PHARMACY, INC., CARLOS DIAZ d/b/a VALLEY VIEW PHARMACY, ALFRED SANGALLI, d/b/a STAR DRUG STORE, BLANCO PHARMACY, INC., BLANCO SOUTHSIDE PHARMACY, INC., DAN PARADA d/b/a DAN'S PHARMACY, RODOLFO L. DAVILA, INC. d/b/a DAVILA PHARMACY, DELLMAR PHARMACIES, INC. d/b/a DELLMAR PHARMACY #4, RONG, INC. d/b/a ECONOMY PHARMACY #1, ZARZAMORA PHARMACY, INC. and WHITE CROSS PROFESSIONAL PHARMACY, INC. d/b/a WHITE CROSS #1 and d/b/a WHITE CROSS #4

v.

GROUP LIFE AND HEALTH INSURANCE COMPANY a/k/a BLUE SHIELD and/or BLUE CROSS-BLUE SHIELD OF TEXAS, WALGREEN TEXAS COMPANY, SOMMERS DRUG STORE, RIEGER-MEDI-SAVE, INC. d/b/a GIBSONS PHARMACY

ORIGINAL COMPLAINT

TO SAID HONORABLE COURT:

Plaintiffs bring this action against defendants for the amount of damages suffered and to be suffered by them due to the defendants' violation of the anti-trust laws of the United States and the State of Texas and allege as follows:

I

This action arises under the Sherman Anti-Trust Act of July 2, 1890, 15 U.S.C.A. Sects. 1-7, and under the Clayton Anti-Trust Act of October 15, 1914, 15 U.S.C.A. section 12 et seq.

II

1. The plaintiff, ROYAL DRUG COMPANY, INC., d/b/a Royal Pharmacy of Castle Hills and Disco Prescription Pharmacy, is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

2. The plaintiff, BLAUSER'S PHARMACY, INC., is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

3. The plaintiff, PARKERS PHARMACY, INC., is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

4. The plaintiff, CHARLES GRIFFIN d/b/a Dellview Drug Store, is a resident of San Antonio, Bexar County, Texas.

5. The plaintiff, JAMES POLLOCK d/b/a Pollock's Pharmacy, is a resident of San Antonio, Bexar County, Texas.

6. The plaintiff, THOMAS J. PARMA d/b/a Parma's Pharmacy, is a resident of San Antonio, Bexar County, Texas.

7. The plaintiff, CRAIG BELL d/b/a Bell Pharmacy, is a resident of San Antonio, Bexar County, Texas.

8. The plaintiff, GEORGE STONE d/b/a Olmos Pharmacy, is a resident of San Antonio, Bexar County, Texas.

9. The plaintiff, ALAMO HEIGHTS PHARMACY, INC., is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

10. The plaintiff, PATTS DRUG, INC. d/b/a Patt's Drug Store No. 1, is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

11. The plaintiff, BAYLOR PARSONS d/b/a Parsons Pharmacy, is a resident of San Antonio, Bexar County, Texas.

12. The plaintiff, HIGHLAND HILLS PHARMACY, INC., is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

13. The plaintiff, ECONODOSE SYSTEMS, INC. d/b/a Medical Center Pharmacy, is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

14. The plaintiff, GUSTAVE HNCIR d/b/a Turners Pharmacists, is a resident of San Antonio, Bexar County, Texas.

15. The plaintiff, PHYSICIAN & SURGEONS PHARMACY, INC., is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

16. The plaintiff, CARLOS DIAZ d/b/a Valley View Pharmacy, is a resident of San Antonio, Bexar County, Texas.

17. The plaintiff, ALFRED SANGALLI d/b/a Star Drug Store is a resident of San Antonio, Bexar County, Texas.

18. The plaintiff, BLANCO PHARMACY, INC., is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

19. The plaintiff, BLANCO SOUTHSIDE PHARMACY, INC., is a corporation, organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

20. The plaintiff, DAN PARADA d/b/a Dan's Pharmacy, is a resident of San Antonio, Bexar County, Texas.

21. The plaintiff, RODOLFO L. DAVILA, INC. d/b/a Davila Pharmacy, is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

22. The plaintiff, DELLMAR PHARMACIES, INC. d/b/a Dellmar Pharmacy #4, is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio Bexar County, Texas.

23. The plaintiff, RONG, INC. d/b/a Economy Pharmacy #1, is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

24. The plaintiff, ZARZARMORA PHARMACY, INC., is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

25. The plaintiff, WHITE CROSS PROFESSIONAL PHARMACY, INC. d/b/a White Cross #1 and White Cross #4, is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in San Antonio, Bexar County, Texas.

All of Plaintiffs own and operate one or more pharmacies in San Antonio, Bexar County, Texas, and are in the business of compounding and dispensing prescription drugs for public sale.

III

1. Defendant GROUP LIFE AND HEALTH INSURANCE COMPANY, a/k/a BLUE SHIELD and/or BLUE CROSS-BLUE SHIELD OF TEXAS, may be served by serving the Insurance Commissioner of the State of Texas in Austin, Texas. Such defendant is hereinafter referred to as "BLUE CROSS-BLUE SHIELD."

2. Defendant WALGREEN TEXAS COMPANY a/k/a WALGREEN DRUG STORES, may be served by serving its Agent for Service, Mary Wilson, 8110 Kempwood, Houston, Texas. Such defendant is hereinafter referred to as "WALGREEN."

3. Defendant SOMMERS DRUG STORES CO., a/k/a SOMMERS REXALL DRUG STORES, CO., may be served by serving its Agent for Service, Walter M. Corrigan, 3130 E. Houston Street, San Antonio, Texas. Such defendant is hereinafter referred to as "SOMMERS."

4. Defendant RIEGER-MEDI-SAVE, INC., d/b/a GIBSONS PHARMACY, may be served by serving the Secretary of State of the State of Texas. Such defendant is hereinafter referred to as "GIBSONS."

IV

1. The defendant, WALGREEN TEXAS CO., is a corporation organized and existing under the laws of the State of Texas, and operates numerous drug stores engaged in the business of compounding and dispensing prescription drugs for public sale under the name of WALGREEN DRUG STORES and in various GLOBE DISCOUNT STORES.

2. The defendant, REIGER-MEDI-SAVE, INC., is a corporation organized and existing under the laws of the State of Texas, which operates numerous drug stores engaged in the business of compounding and dispensing prescription drugs for public sale in GIBSON DISCOUNT STORES.

3. The defendant, SOMMERS DRUG STORES CO., is a corporation organized and existing under the laws of the State of Texas, which operates numerous drug stores engaged in the business of compounding and dispensing prescription drugs for public sale under its own name.

V

1. All of said defendants, other than BLUE CROSS-BLUE SHIELD, are in competition with plaintiffs in connection with the compounding and dispensing of prescription drugs for public sale in San Antonio and Bexar County, Texas.

2. Defendant GROUP LIFE AND HEALTH INSURANCE COMPANY a/k/a Blue Shield and/or Blue Cross-

Blue Shield of Texas, is one of the largest, if not the largest, company engaged in the business of selling insurance coverage providing for payment of part of the cost to its policyholders of drugs and pharmaceutical products, all as more fully set out below.

VI

COUNT ONE

1. Defendants have and are engaged in an agreement, combination and conspiracy to fix the retail price of drugs and pharmaceuticals. Such agreement, combination and conspiracy has been carried out by their entering into an Agreement between defendants and BLUE CROSS-BLUE SHIELD whereby said parties agree upon and fix prices and charges to be charged to the general public for the compounding and dispensing of prescription drugs. Specifically, defendant BLUE CROSS-BLUE SHIELD and each of the other defendants have entered into a Participating Drug Pharmacy Agreement, hereinafter called "Agreement". Said Agreement specifies the amount to be received by each pharmacy for the sale of drugs and other pharmaceuticals dispensed by Defendants to BLUE CROSS-BLUE SHIELD policyholders who have purchased coverage under the BLUE CROSS-BLUE SHIELD prepaid prescription policies. Under such Agreement Blue Cross-Blue Shield agrees to pay for each drug provided an amount equal to the total of the acquisition cost of such drug as defined therein plus a fixed dispensing fee of $2.00 less the applicable policy deductibles.

2. Basically pharmacies which join in such Agreement are reimbursed by BLUE CROSS-BLUE SHIELD for 100% of the acquisition cost, plus the $2.00 fee which is paid by the customer. Pharmacies which have not signed said Agreement are only reimbursed for 75% of the ac-

quisition cost thereof in addition to the $2.00 fee paid by their customers. Such contract and performance under it result in acquisitive, pernicious and blatant economic coercion to force BLUE CROSS-BLUE SHIELD policy[-] holders to deal only with pharmacies which have entered into such Agreement and become part of the unlawful combination, agreement and conspiracy with BLUE CROSS-BLUE SHIELD. Failure to deal with such pharmacists results in such policyholder and pharmacy customer not receiving full reimbursement for the cost of the particular drugs and prescriptions covered by their BLUE CROSS-BLUE SHIELD policy. Defendants and all other pharmacies which have executed such Agreement have entered into a combination[,] conspiracy and agreement to fix prices for the sale of drugs and pharmaceuticals, which is a per se violation of the Federal Anti-Trust Laws, specifically Section 1 of the Sherman Act, and are engaged in horizontal price fixing with respect to dispensing of drugs and pharmaceuticals.

COUNT TWO

1. The foregoing allegations of this complaint are incorporated in this Count Two.

2. The foregoing activities of defendants constitute a group boycott in violation of the Federal Anti-Trust Laws in that the purpose and necessary effect of said combination, agreement and conspiracy is to cause persons holding prepaid prescription coverage under the applicable BLUE CROSS-BLUE SHIELD policies to not deal with plaintiffs and other pharmacies similarly situated, but to deal only with pharmacies which are members of, have participated and joined in such unlawful agreement, combination and conspiracy in violation of the Sherman Act.

COUNT THREE

1. The allegations of Count One above are hereby incorporated by reference.

2. The effect of the combination, agreement and conspiracy is to allocate territories to pharmacists who have signed the Agreement and impose territorial restrictions, all of which are per se violations of the Sherman Act.

COUNT FOUR

1. The allegations of Count One are incorporated herein by reference.

2. The actions alleged constitute violations of the Federal Anti-Trust Law set out above and the Texas Business and Commerce Code and defendants, and each of them, should be enjoined on final hearing from:

A. From agreeing on and fixing prices which individual pharmacists may charge,

B. From engaging in group boycotts,

C. From continuing to utilize and observe the provisions of the Participating Drug Pharmacy Agreement,

D. From requiring pharmacists to enter into contracts which violate the Federal and State Anti-Trust Laws,

E. From entering into any contracts the effect of which is to maintain or set retail prices between such pharmacies and their customers, or

F. Issuing any contract which distinguishes insofar as reimbursement for the purchase price of drugs and other pharmaceuticals between pharmacies which

are part of the illegal agreement, combination and conspiracy, and those which are not part thereof.

G. From agreeing to allocate territories.

COUNT FIVE

1. The foregoing allegations in Count One of this Complaint are incorporated herein by reference.

2. The court has jurisdiction under the causes of action alleged in this Count under the doctrine of pendent jurisdiction.

3. All of such acts and conduct alleged above violate the Texas Business and Commerce Code, Sections 15.01 et seq., commonly known as the Texas Anti-Trust Laws.

COUNT SIX

Plaintiffs' damages and damages to other pharmacies similarly situated who have likewise been injured by defendants' unlawful acts are substantial and are in all probability in millions of dollars, the exact extent of which cannot be determined until Plaintiffs' discovery from defendants is completed and the full extent of such agreement, combination and conspiracy is determined.

COUNT SEVEN

Plaintiffs are entitled to recover reasonable attorneys' fees from defendants in the amount of not less than $50,000.

WHEREFORE each of plaintiffs pray that they have judgment jointly and severally against defendants for treble their damages, for reasonable attorneys' fees, for costs of suit and for injunctive relief as above alleged,

and for such other and further relief to which Plaintiffs are entitled. No immediate emergency action is sought at this time.

/s/ Joel H. Pullen
JOEL H. PULLEN of
TINSMAN & HOUSER, INC.
1900 NBC Building
San Antonio, Texas 78205

Attorneys for Plaintiff

Now come Plaintiffs and demand a jury.

/s/ Joel H. Pullen
JOEL H. PULLEN

ANSWER OF DEFENDANT RIEGER/MEDI-SAVE PHARMACIES, INC., JUNE 20, 1975

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

ORIGINAL ANSWER OF DEFENDANT, RIEGER/MEDI-SAVE PHARMACIES, INC.

Rieger/Medi-Save Pharmacies, Inc., incorrectly designated as Rieger-Medi-Save, Inc., answers plaintiff's Original Complaint as follows:

FIRST DEFENSE

The Complaint fails to state a claim against Rieger/Medi-Save Pharmacies, Inc. upon which relief may be granted.

SECOND DEFENSE

This Court lacks jurisdiction over the matters alleged in the Complaint because of the lack of any requisite effect on commerce.

THIRD DEFENSE

The Complaint fails to state a cause of action against this defendant because Group Life and Health Insurance Company, with whom it is alleged to have conspired, combined and agreed, is not a proper party nor capable of such actions under the Anti-Trust Laws of the United States, because of exemption under the McCarran-Ferguson Act (15 USC § 1011, et seq.).

Answer of Defendant Rieger/Medi-Save Pharmacies, Inc.

FOURTH DEFENSE

The Complaint fails to state a proper cause of action against defendant in its pendant allegations, based on the Texas Anti-Trust Laws, because such an action is not properly maintainable in absence of a proper cause of action under federal law.

FIFTH DEFENSE

The Complaint should be dismissed as to this defendant because the service of process upon it was improper and insufficient.

SIXTH DEFENSE

To the extent the allegations of Plaintiffs' Original Complaint are directed to Rieger/Medi-Save Pharmacies, Inc., it answers paragraph by paragraph, as follows:

I

The allegations of Paragraph I are denied, except it is admitted that plaintiffs' do purport to bring this action under the statutes indicated.

II

This defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations of Paragraph II, sub-paragraphs 1.-25.

III

Defendant is without knowledge sufficient to form a belief as to the truth of the allegations of Paragraph III, sub-paragraphs 1.-3. The allegations of Paragraph III, sub-paragraph 4. are denied.

IV

It is admitted that the defendant, Rieger/Medi-Save Pharmacies, Inc., operates certain drug stores engaged in the business of compounding and dispensing prescription drugs for public sale in certain Gibson Discount stores. The balance of the allegations of Paragraph IV, sub-paragraph 2. are denied.

This defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations of Paragraph IV, sub-paragraphs 1. and 3.

V

This defendant admits that it is engaged in competition with plaintiffs in the compounding and dispensing of prescription drugs for public sale in certain areas of San Antonio and Bexar County, Texas. This defendant is without information sufficient to form a belief as to the truth of the balance of the allegations of Paragraph V, sub-paragraphs 1. and 2.

VI

COUNT ONE

This defendant admits that it entered into an agreement by and between itself and Group Life and Health Insurance Company, subject to terms provided therein. The balance of the allegations of Paragraph VI, sub-paragraphs 1. and 2. are denied.

COUNT TWO

This defendant adopts, in response to the allegations of COUNT TWO, sub-paragraph 1., its respective answers to Paragraphs I through Paragraph VI, COUNT ONE, sub-paragraph 2.

The allegations of COUNT TWO, sub-paragraph 2., are denied.

COUNT THREE

This defendant adopts, in response to the allegations of COUNT THREE, sub-paragraph 1., its answer to the allegations of COUNT ONE, sub-paragraphs 1. and 2. of the Complaint.

The allegations of COUNT THREE, sub-paragraph 2. are denied.

COUNT FOUR

This defendant adopts, in response to the allegations contained in COUNT FOUR, sub-paragraph 1., its answer to COUNT ONE, sub-paragraphs 1. and 2.

The allegations of COUNT FOUR, sub-paragraph 2., are denied.

COUNT FIVE

This defendant adopts, in response to COUNT FIVE, sub-paragraph 1., its answer to COUNT ONE, sub-paragraphs 1. and 2.

The allegations of COUNT FIVE, sub-paragraphs 2. and 3. are denied.

COUNT SIX

The allegations of COUNT SIX are denied.

COUNT SEVEN

The allegations of COUNT SEVEN are denied.

This defendant denies that plaintiffs are entitled to any of the relief demanded or prayed for, and further denies

that it has violated any of the provisions of any acts upon which this action is based.

OTHER PARTIES

To the extent that the allegations of the Complaint are directed to persons or corporations other than Rieger/Medi-Save Pharmacies, Inc., this defendant is without knowledge or information sufficient to form a belief as to the truth of such allegations.

Except as expressly admitted herein, all the allegations of this Complaint relating to Rieger/Medi-Save Pharmacies, Inc. are denied.

WHEREFORE, Rieger/Medi-Save Pharmacies, Inc. prays that plaintiffs take nothing by their suit, that it recover its costs and for such other and further relief to which it may be justly entitled.

Respectfully submitted,

CHARLES R. SHADDOX

By /s/ C. R. Shaddox
2000 Frost Bank Tower
San Antonio, Texas 78205
Attorneys for Defendant, Rieger/Medi-Save Pharmacies, Inc.

Of Counsel:

GROCE, LOCKE & HEBDON
2000 Frost Bank Tower
San Antonio, Texas 78205

Defendant, RIEGER/MEDI-SAVE PHARMACIES, INC., hereby demands a jury.

/s/ C. R. Shaddox
CHARLES R. SHADDOX

[Certificate of Service Omitted in Printing]

ANSWER OF DEFENDANT THE SOMMERS DRUG STORES COMPANY, JUNE 23, 1975

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

ANSWER OF DEFENDANT
THE SOMMERS DRUG STORES COMPANY

THE SOMMERS DRUG STORES COMPANY ("Sommers"), one of the Defendants herein, files this, its Answer to Plaintiffs' Original Complaint, and would show:

First Defense

The Original Complaint fails to state a claim against Sommers upon which relief can be granted.

Second Defense

The Court lacks jurisdiction over the subject matter because:

A. No cause of action has been shown to exist under the acts of Congress regulating commerce or protecting trade and commerce against restraints and monopolies;

B. The lack of any requisite effect on interstate commerce;

C. All of the parties are residents of the State of Texas and no diversity jurisdiction exists; and,

D. In the absence of jurisdiction under federal law there is no pendent jurisdiction.

Third Defense

The Complaint fails to state a claim upon which relief can be granted against Sommers under the antitrust laws

of the United States because the Defendant GROUP LIFE AND HEALTH INSURANCE COMPANY ("Blue Cross") is engaged in the "business of insurance", and all matters alleged by Plaintiffs herein arise out of the "business of insurance", which is regulated by the Insurance Commissioner of the State of Texas and exempt from the provisions of the Sherman and Clayton Acts pursuant to the McCarran-Ferguson Act (15 U.S.C. § 1011, *et seq.*).

Fourth Defense

Sommers answers the allegations of Plaintiffs' Original Complaint in paragraphs numbered to correspond with those of the Original Complaint, as follows:

I.

Sommers denies the allegations contained in Part I of the Complaint.

II.

As to each and every allegation contained in Part II of the Complaint, Sommers denies that it has knowledge or information thereof sufficient to form a belief in connection therewith.

III.

Sommers admits as alleged in Part III, Paragraph No. 3 of the Complaint that its agent for service is Walter N. Corrigan, 3130 E. Houston Street, San Antonio, Texas. As to each and every other allegation contained in said Part III of the Complaint, Sommers denies that it has knowledge or information sufficient to form a belief in connection therewith.

IV.

As to Part IV, Paragraph No. 3 of the Complaint, Sommers admits that it is a corporation duly authorized to do business in Texas and whose principal place of business is Texas, but would show that it is organized under the laws of the State of Maryland, operating numerous drug stores (in Texas only) engaged in the business of compounding and dispensing prescription drugs for public sale under its own name. As to each and every other allegation contained in said Part IV, Sommers does not have knowledge or information sufficient to form a belief in connection therewith.

V.

As to each and every allegation contained in Part V of the Complaint, Sommers denies that it has knowledge or information thereof sufficient to form a belief in connection therewith, except that Sommers admits that it is in competition with other drug stores in San Antonio and Bexar County, Texas.

VI.

COUNT ONE

Sommers admits that it entered into a Participating Drug Pharmacy Agreement on the terms provided therein, solely between itself and Blue Shield. As to each and every other allegation contained in Part VI, Count One of the Complaint, Sommers denies the allegations as to itself, and denies that it has any knowledge or information thereof sufficient to form a belief in connection with allegations made as to other Defendants referred to therein.

Answer of Defendant The Sommers Drug Stores Co.

COUNT TWO

As to the allegations contained in Count Two, Paragraph No. 1, Sommers has previously responded to the incorporated "foregoing allegations" of the Complaint, which answers are here repeated.

As to the allegations contained in Count Two, Paragraph No. 2, Sommers denies the allegations.

COUNT THREE

As to the allegations contained in Count Three, Paragraph No. 1, Sommers has previously responded to the incorporated Count One of the Complaint, which answers are here repeated.

As to the allegations contained in Count Three, Paragraph No. 2, Sommers denies the allegations.

COUNT FOUR

As to the allegations contained in Count Four, Paragraph No. 1, Sommers has previously responded to the incorporated Count One of the Complaint which answers are here repeated.

As to each and every allegation contained in Count Four, Paragraph No. 2 of the complaint, Sommers denies the allegations.

COUNT FIVE

As to the allegations contained in Count Five, Paragraph No. 1, Sommers has previously responded to the incorporated Count One of the Complaint which answers are here repeated.

Answer of Defendant The Sommers Drug Stores Co.

As to each and every allegation contained in Count Five, Paragraphs 2 and 3 of the Complaint, Sommers denies the allegations.

COUNT SIX

As to Count Six, Sommers denies the allegations.

COUNT SEVEN

As to Count Seven, Sommers denies the allegations.

WHEREFORE, Defendant, THE SOMMERS DRUG STORES COMPANY, prays judgment that the Plaintiffs take nothing by reason of their Complaint on file herein but that the same be dismissed without cost to Defendant, and that Defendant recover its costs and further relief to which it may be justly entitled.

Respectfully submitted,

GRESHAM, DAVIS, GREGORY,
WORTHY & MOORE
1800 Frost Bank Tower
San Antonio, Texas 78205

By /s/ Richard B. Moore

Attorneys for Defendant,
The Sommers Drug Stores
Company

Answer of Defendant The Sommers Drug Stores Co.

DEFENDANT SOMMERS' DEMAND FOR JURY

COMES NOW the Defendant, THE SOMMERS DRUG STORES COMPANY, and as is provided by Rule 38 of the Federal Rules of Civil Procedure in United States District Courts (28 U.S.C.A.), requests trial by jury in the above numbered and styled cause.

Dated June 23, 1975.

GRESHAM, DAVIS, GREGORY,
WORTHY & MOORE
1800 Frost Bank Tower
San Antonio, Texas 78205

Attorneys for Defendant,
The Sommers Drug Stores
Company

By /s/ Richard B. Moore
RICHARD B. MOORE

[Certificate of Service Omitted in Printing]

ANSWER OF DEFENDANT GROUP LIFE AND HEALTH INSURANCE COMPANY, JUNE 22, 1975

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

ANSWER OF DEFENDANT GROUP LIFE AND HEALTH INSURANCE COMPANY

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as Blue Shield of Texas ("Blue Shield") (incorrectly designated as Blue Shield and/or Blue Cross-Blue Shield of Texas), one of the Defendants herein, answers Plaintiffs' Original Complaint in this action as follows:

FIRST DEFENSE

The Original Complaint should be dismissed pursuant to Rules 12(b)(6) and 56, Federal Rules of Civil Procedure, because it fails to state a claim against Blue Shield for which relief can be granted.

SECOND DEFENSE

The Original Complaint should be dismissed pursuant to Rules 12(b)(1) and 56, Federal Rules of Civil Procedure, because the matters alleged therein do not have the requisite effect on interstate commerce. Therefore, the Court lacks subject matter jurisdiction of this action.

THIRD DEFENSE

The Original Complaint should be dismissed pursuant to Rules 12(b)(1), 12(b)(6) and 56, Federal Rules of Civil Procedure, because there is no diversity of citizenship

under 28 U.S.C. § 1332. Jurisdiction, if any, is under the antitrust laws of the United States. As shown in Blue Shield's Second Defense above, no federal question arises under the antitrust laws. Therefore, Plaintiffs have failed to state a proper cause of action and the Court does not have subject matter jurisdiction by reason of diversity of citizenship.

FOURTH DEFENSE

The Original Complaint should be dismissed pursuant to Rules 12(b)(1), 12(b)(6) and 56, Federal Rules of Civil Procedure, because in the absence of any cause of action based upon federal law, as shown in Blue Shield's Second Defense and Third Defense, above, this Court may not entertain Plaintiffs' pendent claims based upon alleged violations of the Texas antitrust laws.

FIFTH DEFENSE

The Original Complaint should be dismissed pursuant to Rules 12(b)(6) and 56, Federal Rules of Civil Procedure, because the same fails to state a cause of action against Blue Shield. Blue Shield is engaged in the "business of insurance", and all matters alleged by Plaintiffs herein arise out of the "business of insurance", which "business" is regulated by state law. Therefore, Blue Shield is exempted from application of the Sherman and Clayton Acts by the provisions of the McCarran-Ferguson Act (15 U.S.C. § 1011, *et seq.*).

SIXTH DEFENSE

The claims set forth in the Original Complaint are barred in whole or in part by laches.

SEVENTH DEFENSE

Blue Shield answers the allegations of the Original Complaint in paragraphs numbered to correspond with those of the Original Complaint, as follows:

I.

Denied; however, Blue Shield admits that proper causes of action may arise under the statutes alleged.

II.

1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24 and 25. Blue Shield is without knowledge or information sufficient to form a belief as to the truth of the allegations.

Blue Shield is without knowledge or information sufficient to form a belief as to the truth of the allegations contained in the last (unnumbered) paragraph of paragraph II of the Original Complaint.

III.

1. Blue Shield denies the first sentence. The second sentence requires no admission or denial; however, this Defendant states that it has been incorrectly designated as "Blue Shield and/or Blue Cross-Blue Shield of Texas".

2. Blue Shield is without knowledge or information sufficient to form a belief as to the truth of the first sentence. The second sentence requires no admission or denial.

3. Blue Shield is without knowledge or information sufficient to form a belief as to the truth of the first sentence. The second sentence requires no admission or denial.

4. Blue Shield is without knowledge or information sufficient to form a belief as to the truth of the first sentence. The second sentence requires no admission or denial.

IV.

1, 2 and 3. Blue Shield is without knowledge or information sufficient to form a belief as to the truth of the allegations.

V.

1. Blue Shield is without knowledge or information sufficient to form a belief as to the truth of the allegations.

2. Blue Shield admits that it is one of the largest companies engaged in the business of selling insurance coverage in the State of Texas providing for payment of part of the cost to its policyholders of prescription drugs; however, denies the remainder of this paragraph.

VI.

COUNT ONE

1. Blue Shield denies the first, second, fourth and fifth sentences. Blue Shield admits the third sentence and says that the Agreement is a document which speaks for itself.

2. Blue Shield admits the first sentence and denies the second, third, fourth and fifth sentences.

COUNT TWO

1. For each allegation incorporated by reference from the Original Complaint, Blue Shield incorporates its answering paragraph with the same force and effect as if the answer were set forth here in full.

2. Denied.

COUNT THREE

1. For each allegation incorporated by reference from Count One of the Original Complaint, Blue Shield incorporates its answering paragraph with the same force and effect as if the answer were set forth here in full.

2. Denied.

COUNT FOUR

1. For each allegation incorporated by reference from Count One of the Original Complaint, Blue Shield incorporates its answering paragraph with the same force and effect as if the answer were set forth here in full.

2. Denied.

COUNT FIVE

1. For each allegation incorporated by reference from Count One of the Original Complaint, Blue Shield incorporates its answering paragraph with the same force and effect as if the answer were set forth here in full.

2. Denied.

3. Denied.

COUNT SIX

Denied.

COUNT SEVEN

Blue Shield denies the allegations of Count Seven and says that Plaintiffs are not entitled, in law, or in fact, to any recovery or relief from Blue Shield.

WHEREFORE, Blue Shield prays that Plaintiffs take nothing by their suit herein, that it recover its costs and

have such other and further relief to which it may be justly entitled.

Respectfully submitted,

COX, SMITH, SMITH, HALE & GUENTHER INCORPORATED
500 National Bank of Commerce Building
San Antonio, Texas 78205
512/224-4281

/s/ J. Burleson Smith
J. BURLESON SMITH

[Certificate of Service Omitted in Printing]

ANSWER OF DEFENDANT WALGREEN TEXAS CO., JUNE 27, 1975

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

ANSWER OF DEFENDANT WALGREEN TEXAS CO.

WALGREEN TEXAS CO. ("WALGREEN"), one of the Defendants herein, files this, its Original Answer to Plaintiffs' Complaint:

FIRST DEFENSE

Plaintiffs' Original Complaint should be dismissed for the reason that it fails to state a claim for which relief can be granted under the Anti-Trust Laws of the United States in that the matters alleged by Plaintiffs did not occur in or substantially affect interstate commerce.

SECOND DEFENSE

Plaintiffs' Complaint should be dismissed for the reason that, since no federal question arises under the Anti-Trust Laws and there is no diversity of citizenship between Plaintiffs and Defendants, this Court does not have jurisdiction.

THIRD DEFENSE

Plaintiffs' Original Complaint should be dismissed for the reason that it fails to state a cause of action against this Defendant because the Defendant GROUP LIFE AND HEALTH INSURANCE COMPANY, with whom it is alleged to have conspired, is engaged in the "business of insurance" and which "business" is regulated by

the Insurance Commissioner of the State of Texas, and, therefore, under the Anti-Trust Laws of the United States, any of such actions are exempt under the McCarran-Ferguson Act (15 U.S.C., Sec. 1011, et seq.).

FOURTH DEFENSE

Plaintiffs' Complaint should be dismissed because, in the absence of any cause of action based upon federal law, this Court has no pendent jurisdiction to entertain any claim based upon an alleged violation of the Texas Anti-Trust Laws.

FIFTH DEFENSE

WALGREEN answers the allegations of Plaintiffs' Complaint as follows:

I

This Defendant denies the allegations contained in Paragraph I of the Complaint that Plaintiffs have any cause of action against it, but would admit that Plaintiffs purport to bring such action under the Statutes as alleged.

II

This Defendant does not have sufficient information as to the allegations with respect to the Plaintiffs as contained in Paragraph II of the Complaint, therefore, can neither admit nor deny such allegations.

III

This Defendant admits the allegations contained in Paragraph III of the Complaint.

IV

This Defendant admits the allegations contained in Sub-Paragraph 1 of Paragraph IV of the Complaint, and, as to Sub-Paragraphs 2 and 3, this Defendant does not have sufficient information regarding the correct corporate names or incorporation of the other Defendants, therefore, can neither admit nor deny such allegations, but admits such Defendants do operate drug stores engaged in compounding and dispensing of prescription drugs.

V

This Defendant admits the allegations contained in Paragraph V of the Complaint.

VI

COUNT ONE

This Defendant admits it has entered into a Participating Drug Pharmacy Agreement with the Defendant GROUP LIFE AND HEALTH INSURANCE COMPANY as alleged in Paragraph VI, Count One of the Complaint, however, denies that the operation under such Agreement, as set out by its terms and conditions, is any conspiracy or combination to fix retail prices of drugs and pharmaceuticals and further denies that this Defendant has committed any act which is in violation of the Federal Anti-Trust Laws.

COUNT TWO

This Defendant hereby incorporates by reference its answers to Plaintiffs' Complaint, as incorporated in Sub-Paragraph 1 of Count Two of the Complaint.

Answer of Defendant Walgreen Texas Co.

This Defendant denies the allegations contained in Sub-Paragraph 2 of Count Two of Plaintiffs' Complaint.

COUNT THREE

This Defendant hereby incorporates by reference its answers to the allegations of Count One, which are incorporated by reference in Sub-Paragraph 1 of Count Three of the Complaint.

This Defendant denies the allegations contained in Sub-Paragraph 2 of Count Three of the Complaint.

COUNT FOUR

This Defendant hereby incorporates by reference its answers to the allegations of Count One, which are incorporated by reference in Sub-Paragraph 1 of Count Four of the Complaint.

This Defendant denies the allegations contained in Sub-Paragraph 2 of Count Four of the Complaint.

COUNT FIVE

This Defendant hereby incorporates by reference its answers to the allegations of Count One, which are incorporated by reference in Sub-Paragraph 1 of Count Five of the Complaint.

This Defendant denies the allegations contained in Sub-Paragraphs 2 and 3 of Count Five of the Complaint.

COUNT SIX

This Defendant denies the allegations contained under Count Six of the complaint.

Answer of Defendant Walgreen Texas Co.

COUNT SEVEN

This Defendant denies the allegations contained in Count Seven of the Complaint.

Defendant WALGREEN TEXAS CO. prays that Plaintiffs recover nothing of and from this Defendant, and that this suit be dismissed at the cost of Plaintiffs.

Respectfully submitted,

/s/ Wm. C. Church, Jr.
WM. C. CHURCH, JR.
8700 Tesoro Drive, Suite 120
Post Office Box 17409
San Antonio, Texas 78217
(512) 828-8261

Attorney for Defendant
Walgreen Texas Co.

Of Counsel:

KAMPMANN, CHURCH & BURNS
8700 Tesoro Drive, Suite 120
San Antonio, Texas 78217

JOINT MOTION TO SUSPEND DISCOVERY AND TO MODIFY ORDER PRELIMINARY TO PRE-TRIAL CONFERENCE, JANUARY 21, 1976

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

JOINT MOTION TO SUSPEND DISCOVERY AND TO MODIFY ORDER PRELIMINARY TO PRE-TRIAL CONFERENCE

Plaintiffs and Defendants, Group Life and Health Insurance Company, also known as Blue Shield of Texas, Walgreen Texas Co., The Sommers Drug Stores Company and Rieger/Medi-Save Pharmacies, Inc., jointly move the Court for an order suspending discovery in this action and modifying the Court's Order Preliminary to Pre-Trial Conference entered herein on August 7, 1975.

In support of this Motion, Plaintiffs and Defendants would show that:

1. Plaintiffs have filed this action against Defendants alleging violations of the Federal antitrust laws and the antitrust laws of the State of Texas.

2. In their respective answers filed herein, Defendants have each asserted numerous defenses to Plaintiffs' allegations, including among others, the defense of the antitrust exemption provided under the McCarran-Ferguson Act (15 U.S.C. § 1011, et seq.), which defenses, if determined to be valid, will be dispositive of this action.

3. Plaintiffs and Defendants have completed substantial discovery through production of documents and depositions.

4. Extensive additional discovery is planned (notices for 20 proposed depositions have been filed) and will be necessary to properly prepare for the trial of this case.

5. Plaintiffs and Defendants, by and through their respective attorneys of record, have agreed that in order to prevent the unnecessary expenditure of money, time and effort of the parties and time and effort of the Court, the validity of the McCarran-Ferguson defenses, as asserted by Defendants, should be presented to the Court for a determination prior to continuing with costly and time consuming discovery procedures.

WHEREFORE, Plaintiffs and Defendants jointly move the Court to enter an Order as follows:

A. Suspending all discovery in this action in order that Defendants may present their McCarran-Ferguson Act defenses to the Court for determination.

B. On or before thirty (30) days after the entry of an Order Suspending Discovery, Defendants shall file appropriate motions to dismiss based upon their defenses asserted under the McCarran-Ferguson Act, together with any appropriate supporting materials and memorandum briefs.

C. On or before twenty (20) days after the motions and briefs of Defendants are filed, Plaintiffs shall file their responses and briefs, together with any necessary supporting materials.

D. On or before ten (10) days after the responses and briefs of Plaintiffs are filed, Defendants shall file any replies that they deem necessary, together with any necessary supplemental supporting materials. All discovery shall be suspended pending a final determination of the validity of the McCarran-Ferguson Act defenses asserted by Defendants.

E. If it is ultimately determined by the Court or by an appellate court that the McCarran-Ferguson Act defenses of Defendants are not valid, the parties shall complete discovery on the merits within ninety (90) days after the date of such final determination.

F. A conference of attorneys will be held on or before thirty (30) days after the completion of discovery.

G. Counsel for the respective parties will submit their proposed agreed pre-trial orders within sixty (60) days after the completion of discovery.

H. In the event counsel are unable to agree on a form of a proposed agreed pre-trial order, then counsel for each party is directed to submit his version of an appropriate pre-trial order within ten (10) days after the expiration of the date set forth in Paragraph G hereof.

Respectfully submitted,

TINSMAN & HOUSER, INC.
1900 National Bank of
Commerce Bldg.
San Antonio, Texas 78205

By: /s/ Joel H. Pullen
JOEL H. PULLEN
Attorneys for Plaintiffs

COX, SMITH, SMITH, HALE
& GUENTHER INCORPORATED
500 National Bank of
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WILLIAM C. CHURCH, JR.
Attorneys for Defendant
Walgreen Texas Co.

GRESHAM, DAVIS, GREGORY,
WORTHY & MOORE
1800 Frost Bank Tower
San Antonio, Texas 78205

By: /s/ Richard B. Moore
RICHARD B. MOORE
Attorneys for Defendant
The Sommers Drug Stores
Company

ORDER OF UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF TEXAS APPROVING JOINT MOTION TO SUSPEND DISCOVERY AND TO MODIFY ORDER PRELIMINARY TO PRE-TRIAL CONFERENCE, JANUARY 23, 1976

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

Civil Action No. SA-75-CA-131

ROYAL DRUG COMPANY, INC. d/b/a/ ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, BLAUSER'S PHARMACY, INC., PARKERS PHARMACY, INC., CHARLES GRIFFIN d/b/a DELLVIEW DRUG STORE, JAMES POLLOCK, d/b/a/ POLLOCK'S PHARMACY, THOMAS J. PARMA, d/b/a PARMA'S PHARMACY, CRAIG BELL, d/b/a BELL PHARMACY, GEORGE STONE, d/b/a OLMOS PHARMACY, ALAMO HEIGHTS PHARMACY, INC., PATTS DRUG, INC. d/b/a PATT'S DRUG STORE NO. 1, BAYLOR PARSONS d/b/a PARSONS PHARMACY, HIGHLAND HILLS PHARMACY, INC., ECONODOSE SYSTEMS, INC. d/b/a MEDICAL CENTER PHARMACY, GUSTAVE HNCIR, d/b/a TURNERS PHARMACISTS, PHYSICIAN & SURGEONS PHARMACY, INC., CARLOS DIAZ d/b/a VALLEY VIEW PHARMACY, ALFRED SANGALLI, d/b/a STAR DRUG STORE, BLANCO PHARMACY, INC., BLANCO SOUTHSIDE PHARMACY, INC., DAN PARADA d/b/a DAN'S PHARMACY, RODOLFO L. DAVILA, INC. d/b/a DAVILA PHARMACY, DELLMAR PHARMACIES INC. d/b/a DELLMAR PHARMACY #4, RONG, INC. d/b/a ECONOMY PHARMACY #1, ZARZAMORA PHARMACY, INC. and WHITE CROSS PROFESSIONAL PHARMACY, INC. d/b/a WHITE CROSS #1 and d/b/a WHITE CROSS #4

v.

GROUP LIFE AND HEALTH INSURANCE COMPANY a/k/a BLUE SHIELD and/or BLUE CROSS-BLUE SHIELD OF

Order Approving Joint Motion to Suspend Discovery

TEXAS, WALGREEN TEXAS COMPANY, SOMMERS DRUG STORE, RIEGER-MEDI-SAVE, INC. d/b/a GIBSONS PHARMACY

ORDER APPROVING JOINT MOTION TO SUSPEND DISCOVERY AND TO MODIFY ORDER PRELIMINARY TO PRE-TRIAL CONFERENCE

On this 23rd day of January, 1976, came on to be considered the Joint Motion to Suspend Discovery and to Modify Order Preliminary to Pre-Trial Conference filed by the parties herein. Having reviewed the Motion and the file in this cause, the Court finds that reasonable grounds exist for the granting of such Motion.

Accordingly, it is hereby ORDERED that the Joint Motion to Suspend Discovery and to Modify Order Preliminary to Pre-Trial Conference should be and the same is hereby and in all things GRANTED.

1. As of this date, all discovery in this action is suspended in order that Defendants may present their McCarran-Ferguson Act defenses to the Court for determination.

2. On or before thirty (30) days after date hereof, Defendants shall file appropriate motions to dismiss based upon their defenses asserted under the McCarran-Ferguson Act, together with any appropriate supporting materials and memorandum briefs.

3. On or before twenty (20) days after the motions and briefs of Defendants are filed, Plaintiffs shall file their responses and briefs, together with any necessary supporting materials.

4. On or before ten (10) days after the responses and briefs of Plaintiffs are filed, Defendants shall file any replies that they deem necessary, together with any nec-

essary supplemental supporting materials. All discovery shall be suspended pending a final determination of the validity of the McCarran-Ferguson Act defenses asserted by Defendants.

5. If it is ultimately determined by the Court or by an appellate court that the McCarran-Ferguson Act defenses of Defendants are not valid, the parties shall complete discovery on the merits within ninety (90) days after the date of such final determination.

6. A conference of attorneys will be held on or before thirty (30) days after the completion of discovery.

7. Counsel for the respective parties will submit their proposed agreed pre-trial orders within sixty (60) days after the completion of discovery.

8. In the event counsel are unable to agree on a form of a proposed agreed pre-trial order, then counsel for each party is directed to submit his version of an appropriate pre-trial order within ten (10) days after the expiration of the date set forth in Paragraph 7 hereof.

ENTERED this 23rd day of January, 1976.

/s/ John H. Wood, Jr.
JOHN H. WOOD, JR.
United States District Judge

APPROVED:

TINSMAN & HOUSER, INC.
1900 National Bank of Commerce Bldg.
San Antonio, Texas 78205

By: /s/ Joel H. Pullen
JOEL H. PULLEN

Attorneys for Plaintiffs

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Attorneys for Defendant
Walgreen Texas Co.

GRESHAM, DAVIS, GREGORY, WORTHY & MOORE
1800 Frost Bank Tower
San Antonio, Texas 78205

By: /s/ Richard B. Moore
RICHARD B. MOORE
Attorneys for Defendant
The Sommers Drug Stores Company

MOTION OF DEFENDANT GROUP LIFE AND HEALTH INSURANCE COMPANY TO DISMISS, FEBRUARY 23, 1976

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

MOTION OF DEFENDANT
GROUP LIFE AND HEALTH INSURANCE COMPANY
TO DISMISS

Defendant Group Life and Health Insurance Company, also known as Blue Shield of Texas ("Blue Shield") (incorrectly designated by Plaintiffs as Blue Shield and/or Blue Cross-Blue Shield of Texas), moves the Court to dismiss Plaintiffs' Original Complaint pursuant to Rules 12(b) and 56, Federal Rules of Civil Procedure, and bases this Motion on the following grounds:

1. This Court lacks jurisdiction over the subject matter of the Complaint because Blue Shield is engaged in the "business of insurance", and all matters alleged by Plaintiffs herein arise out of the "business of insurance", which "business" is regulated by state law. Therefore, Blue Shield is exempted from the application of the Sherman and Clayton Acts by the provisions of the McCarran-Ferguson Act (15 U.S.C. § 1011, *et seq.*).

2. The Complaint fails to state a claim against Blue Shield upon which relief can be granted because, as shown in paragraph 1 above, the Court lacks jurisdiction over the subject matter.

3. In the absence of any action based upon federal law, as shown above, this Court may not entertain Plaintiffs' pendent claims based upon alleged violations of the Texas antitrust laws.

4. Blue Shield further moves the Court to treat this Motion as one for summary judgment pursuant to Rule 56, Federal Rules of Civil Procedure, and to consider the following:

A. The Affidavit to Steve G. McDonald which is attached hereto as Exhibit "A" and incorporated herein by reference; and

B. The oral depositions of A. W. Pogue, Robert C. McAnelly, Paul D. Connor and Donald H. Bunnell, previously filed in the records of this proceeding, and incorporated herein by reference.

5. This Motion is supported by a memorandum brief filed contemporaneously herewith.

WHEREFORE, Blue Shield prays that this Court dismiss Plaintiffs' Original Complaint and that this Motion be treated as one for summary judgment.

Respectfully submitted,

COX, SMITH, SMITH, HALE &
GUENTHER INCORPORATED
500 National Bank of
Commerce Bldg.
San Antonio, Texas 78205

Motion of Defendant Group Life and Health to Dismiss

/s/ J. Burleson Smith
J. BURLESON SMITH

/s/ Keith E. Kaiser
KEITH E. KAISER

/s/ R. Laurence Macon
R. LAURENCE MACON

[Certificate of Service Omitted in Printing]

AFFIDAVIT OF STEVE G. McDONALD IN SUPPORT OF MOTION OF DEFENDANT GROUP LIFE AND HEALTH INSURANCE COMPANY TO DISMISS, FEBRUARY 23, 1976

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

AFFIDAVIT OF STEVE G. McDONALD IN SUPPORT OF MOTION OF DEFENDANT GROUP LIFE AND HEALTH INSURANCE COMPANY TO DISMISS

STATE OF TEXAS)
)
COUNTY OF DALLAS)

The witness, having been duly sworn, deposes and says:

1. My name is Steve G. McDonald. I reside at 6517 Turner Way, Dallas, Texas.

2. I make this Affidavit in support of the Motion of Defendant Group Life and Health Insurance Company to Dismiss and I have personal knowledge of the facts set forth herein.

3. I am an attorney and I have been licensed to practice in the State of Texas continuously since 1966. I am employed by Group Hospital Service, Inc. ("GHS").

4. With the exception of a nine-month period, I have been continuously employed by GHS since 1960. Since January, 1966, I have been in the legal division of GHS as one of its associate counsel.

5. GHS is a non-profit corporation duly organized and existing under Chapter 20 of the Texas Insurance Code, Tex. Ins. Code Ann. art. 20.01, *et seq.* GHS issues pre-

paid coverage which provides hospital benefits to its subscribers through contracts between the company and hospitals. GHS also issues prepaid coverage which provides benefits to its subscribers on an indemnity basis for medical and surgical care.

6. The Blue Cross service mark is owned by the Blue Cross Association. GHS is authorized by the Blue Cross Association to use the Blue Cross service mark and operates under the name of Blue Cross of Texas. Hereinafter, GHS will be referred to as "Blue Cross".

7. Group Life and Health Insurance Company ("GL&H") is a corporation duly organized and existing under Chapter 3 of the Texas Insurance Code, Tex. Ins. Code Ann. art. 3.01, *et seq.*, and is authorized by the State Board of Insurance of the State of Texas to transact the business of life, health and accident insurance within the State of Texas.

8. The Blue Shield service mark is owned by the National Association of Blue Shield Plans. GL&H is authorized by the National Association of Blue Shield Plans to use the Blue Shield service mark and operates under the trade name of Blue Shield of Texas. Hereinafter, GL&H will be referred to as "Blue Shield".

9. With the exception of a few qualifying shares issued to directors of Blue Shield, all of the stock of Blue Shield is owned by Blue Cross, a non-profit corporation.

10. The legal staff of Blue Cross, of which I am a member, provides legal services to Blue Shield pursuant to a management contract between the two companies.

11. Since 1968, I have been primarily responsible for the filing of Blue Shield's policy forms and related documents with the Commissioner of Insurance of the State of Texas. Since 1966, I have participated in the preparation of Blue Shield's policy forms and related documents.

12. In 1969, Blue Shield determined to issue prescription drug insurance coverage in the form of a supplemental policy to certain of its medical-surgical policies. I assisted in the preparation of the supplemental policy. A true and correct copy of the supplemental policy is attached hereto as Exhibit "A" and incorporated herein by reference.

13. Thereafter, I assisted in the preparation of the Participating Drug Pharmacy Agreement, the purposes of which were to comply with and effectuate the terms and provisions of the prescription drug insurance policy, to satisfy Blue Shield's contractual obligations to its insureds and to establish an efficient system of claims-settlement procedures for the insureds under the policy. A true and correct copy of the Participating Drug Pharmacy Agreement is attached hereto as Exhibit "B" and incorporated herein by reference.

14. On March 14, 1969, prior to issuance or use of the prescription drug insurance policy or the Participating Drug Pharmacy Agreement, I forwarded two copies of each to the State Board of Insurance, pursuant to the provisions of Tex. Ins. Code Ann. art. 3.42. A true and correct copy of my letter of transmittal dated March 14, 1969, is attached hereto as Exhibit "C" and incorporated herein by reference.

15. Thereafter, Blue Shield received from the Commissioner of Insurance a copy of Official Order No. 29701, dated June 18, 1969, which disapproved the prescription drug insurance program. A true and correct copy of Official Order No. 29701, dated June 18, 1969, is attached hereto as Exhibit "D" and incorporated herein by reference.

16. As a result of the disapproval order, Blue Shield did not issue or use the proposed prescription drug insurance program.

17. Subsequently, Blue Shield received from the Commissioner of Insurance a copy of Official Order No. 30413, dated September 30, 1969, which Order exempted the prescription drug insurance program from the approval requirements of Tex. Ins. Code Ann. art. 3.42, and which authorized Blue Shield to issue and use the program in the State of Texas. A true and correct copy of Official Order No. 30413, dated September 30, 1969, is attached hereto as Exhibit "E" and incorporated herein by reference.

18. It is Blue Shield's policy that the option of entering into a Participating Drug Pharmacy Agreement is available to any licensed pharmacy in the State of Texas. In 1969, Blue Shield made a statewide mailing to licensed pharmacies advising them of this option.

19. Since September 30, 1969, Blue Shield has conducted the prescription drug insurance program as authorized by the exemption order (Exhibit "E").

20. The exemption order (Exhibit "E") did not relieve Blue Shield from any of the regulatory requirements set out in the Texas Insurance Code, nor did it relieve Blue Shield from any of the regulation or supervision established by the State Board of Insurance. In conducting the prescription drug insurance program, Blue Shield has continued to be subject to all of the statutory and administrative regulations of the State of Texas and the State Board of Insurance.

21. In 1974 Blue Shield agreed with Bexar County Medical Foundation to provide certain group hospitalization and medical-surgical insurance coverage to Bexar County groups desiring such coverage. Included in the proposed coverage was prescription drug insurance.

22. I assisted in preparing the prescription drug insurance policy form and other documents necessary for

Blue Shield to be able to provide such coverage. The prescription drug insurance program prepared for use in connection with such coverage is virtually identical to the program submitted to the State Board of Insurance in 1969.

23. On September 23, 1974, prior to issuance or use of any of the policies proposed under the agreement with Bexar County Medical Foundation, I forwarded a copy of each of them to the State Board of Insurance, pursuant to Tex. Ins. Code Ann. art. 3.42. True and correct copies of the prescription drug insurance policy and my letter of transmittal dated September 23, 1974, are attached hereto as Exhibits "F" and "G", respectively, and incorporated herein by reference.

24. Thereafter, Blue Shield received from the Commissioner of Insurance a copy of Official Order No. 45511, dated October 1, 1974, which approved, among other things, the Bexar County prescription drug insurance program. A true and correct copy of Official Order No. 45511, dated October 1, 1974, is attached hereto as Exhibit "H" and incorporated herein by reference. Since receipt of Official Order No. 45511, Blue Shield has been issuing the prescription drug insurance to groups in Bexar County, Texas.

25. After receipt of the approval order (Exhibit "H"), Blue Shield offered to virtually all licensed pharmacies in San Antonio, Texas, the opportunity of entering into a Participating Drug Pharmacy Agreement.

26. Blue Shield has not been notified by the Commissioner of Insurance of Texas of any intention to amend, modify or withdraw the approval order (Exhibit "H").

27. The Attorney General of Texas has initiated no action against Blue Shield as a result of its issuance or use of the prescription drug insurance program.

Affidavit of Steve G. McDonald

28. In all operations under the prescription drug insurance program, Blue Shield has transacted no business other than the business of insurance pursuant to the authority granted by the State Board of Insurance. Blue Shield's conduct under the program has always been with a view toward strict compliance with the statutory and regulatory requirements of the State of Texas and the state agencies that regulate Blue Shield's business.

29. Blue Shield is not engaged in the sale or dispensing of prescription drugs as a manufacturer, wholesaler or retailer. Blue Shield is engaged solely in transacting the business of life, health and accident insurance.

30. Nine of the eighteen Plaintiffs in this action are Participating Pharmacies pursuant to a Participating Drug Pharmacy Agreement with Blue Shield.

/s/ Steve G. McDonald
STEVE G. MCDONALD

SUBSCRIBED AND SWORN TO BEFORE ME this 19 day of February, 1976.

/s/ Betty Jane McKinney
BETTY JANE MCKINNEY

Notary Public in and for
Dallas County, Texas

GROUP LIFE AND HEALTH INSURANCE COMPANY DRUG SUPPLEMENT POLICY, DATED APRIL 1, 1969 (ATTACHED AS "EXHIBIT A" TO AFFIDAVIT OF STEVE G. McDONALD, FEBRUARY 23, 1976)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

GROUP LIFE & HEALTH
Insurance Company

[LOGO]

Dallas, Texas
has issued this

DRUG SUPPLEMENT

to the

EXPERIENCE RATED GROUP
MEDICAL-SURGICAL INSURANCE POLICY

NO. 123456

issued heretofore or simultaneously herewith, to

XYZ COMPANY, INC.

(therewith and herein called the Employer)

as of April 1, 1969

(herein called the supplemental policy date)

and thereby agrees to provide the
additional benefits detailed herein,

all in accordance with the conditions and provisions hereof, including those set out on the following pages which are a part of this supplement as fully as if recited over the signatures hereto affixed.

This supplement becomes effective on the supplemental policy date, and is issued in consideration of the application herefor made by the Employer. It will be continued

in force subject to the timely payment of premiums herefor, until terminated in accordance with the provisions of the Article captioned "Termination of Drug Coverage."

IN WITNESS WHEREOF, the Insurer has caused this supplement to be executed at its Home Office in Dallas, Texas.

President

Countersigned:

Registrar

[Disapproved By Order No. 29701, June 18, 1969,
Commissioner of Insurance, State of Texas]

ARTICLE I—SUPPLEMENTAL DEFINITIONS

AS USED HEREIN:

A. GROUP HOSPITALIZATION CONTRACT means an instrument issued by Group Hospital Service, Inc. of Dallas, Texas to the Employer, bearing the same number as that appearing on the "Experience Rated Group Medical-Surgical Insurance Policy" described on the face page hereof, including any supplements thereto.

B. GROUP MEDICAL-SURGICAL INSURANCE POLICY means the "Experienced Rated Group Medical-Surgical Insurance Policy" described on the face page hereof.

C. BASIC COVERAGE means the total amount of protection afforded a participant by both the group hospitalization contract and the group medical-surgical insurance policy on account of expense incurred for drugs and medicines.

D. COVERED DRUGS means any Prescription Legend Drug or injectable insulin:

(1) which is ordered by a physician;

(2) for which a written prescription order is customarily prepared;

(3) for which a separate charge is customarily made; and

(4) which is not entirely consumed at the time and place that the prescription order is written.

E. PRESCRIPTION LEGEND DRUG means any medicinal substance—the label of which, under the Federal Food, Drug, and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription."

F. DRUG DEDUCTIBLE means the amount to be paid by a participant toward the cost of the initial purchase of each covered drug and toward the cost of each refill purchase of each covered drug and for each such purchase and is equal to the amount specified in Item 20 of the schedule.

G. PRESCRIPTION ORDER means a request for medication by a physician.

H. PHARMACY means a licensed establishment where Prescription Legend Drugs are dispensed by a person who is not a practitioner of the healing arts and who is licensed to dispense such drugs under the laws of the state in which he practices.

I. PROVIDER means any pharmacy, physician, or any other person or organization legally licensed to dispense drugs.

J. PARTICIPATING PROVIDER means a provider located in the State of Texas with which the Insurer or Group Hospital Service, Inc. of Dallas, Texas, has entered into a written contract for the rendition of covered drugs for which benefits are provided by this supplement, or any provider located outside the State of Texas with which any other Blue Cross or Blue Shield Plan has entered into such a contract.

K. NON-PARTICIPATING PROVIDER means a provider who is not a participating provider.

ARTICLE II—TERMS AND PROVISIONS

A. All definitions, limitations, and provisions recited in the group medical-surgical insurance policy are hereby adopted and shall be construed to apply in like manner and with equal force to this supplement, any provisions insofar as they are in conflict with provisions

herein contained, in which case the provisions of this supplement shall govern in any interpretations of rights or obligations accruing hereunder.

B. It is hereby specially declared that the non-duplication provisions set forth in Article IV, Section F, of the group medical-surgical insurance policy are applicable to this supplement except insofar as they are modified by the provisions of the following subsections:

1. Determination of drug benefits under this supplement shall be made in relation to each "claim," consisting of any combination of charges for covered drugs which are incurred within a calendar year and submitted at one time by or on behalf of a participant to the Insurer at his request for payment of drug benefits applicable thereto.

2. When the non-duplication provisions are applicable, the benefits of the other coverage and all benefits provided under the basic coverage on the items composing the claim shall be deducted from the charges for all such items, and the Insurer will pay the remainder; provided, however, that in no event shall these provisions be construed to increase the amount of total benefits which would be payable under this supplement on account of such claim in the absence of other coverage.

ARTICLE III—BENEFITS

A. Subject to the exclusions, limitations, and all other terms and provisions set forth herein, any participant shall be entitled to receive covered drugs from any participating provider as a benefit hereunder and shall be required to pay no more than the drug deductible for each of such covered drugs.

B. Any participant receiving covered drugs from a non-participating provider shall be entitled to benefits equal to 75% of the result of the usual and customary charges for such covered drugs as determined by the Insurer, reduced by the drug deductible for such covered drugs; except that for covered drugs received from a non-participating provider located outside of the State of Texas, such participant shall be entitled to benefits equal to 100% of the usual and customary charges for such covered drugs, reduced by the drug deductible for each such covered drugs.

C. Payment of benefits by the Insurer to the provider or to the Employer, as the Insurer may elect, shall constitute full discharge of all responsibility of the Insurer to the employee on account of care rendered to any participant under his coverage.

ARTICLE IV—LIMITATIONS AND EXCLUSIONS

In addition to the limitations and exclusions stipulated in Article VI of the group medical-surgical insurance policy, it is provided that no drug benefit shall be available for any of the following:

A. Any charge for a contraceptive medication, even if such medication is a Prescription Legend Drug, and any charge for therapeutic devices or appliances (including but not by way of limitation, hypodermic needles, syringes, support garments, and other non-medicinal substances) regardless of their intended use.

B. Any charge for services other than Covered Drugs, including administration of a Prescription Legend Drug or injectable insulin.

C. The charge for more than a 34-day supply of a medication, except that Blue Cross-Shield will cover 100

unit doses (e.g. tablet or capsule) of a natural thyroid product and 100 unit doses of nitroglycerine.

D. The charge for any prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from the physician's order.

E. Covered Drugs for which no charge is customarily made.

F. Covered Drugs to the extent that a benefit is provided therefor under the basic coverage.

ARTICLE V—TERMINATION OF DRUG COVERAGE

A. This supplement and coverage of all participants hereunder shall automatically terminate:

1. When the group medical-surgical insurance policy is terminated for any reason;

2. Upon default in payment of supplemental premiums, subject to the grace period and reinstatement provided for in the group medical-surgical insurance policy;

3. Upon cancellation of this supplement in any manner as specified in the group medical-surgical insurance policy for cancellation thereof.

B. The coverage of any participant under this supplement shall automatically terminate when his coverage under the group medical-surgical insurance policy is terminated, subject, however, to refund of supplemental premiums paid in advance, as therein provided.

C. Under no circumstances shall the Plan be obligated to notify any participant of the termination of this supplement or of his coverage hereunder.

Group Life and Health Drug Supplement Policy

D. No conversion privilege afforded a participant under the group medical-surgical insurance policy shall be deemed to apply to this supplement.

ARTICLE VI—GENERAL PROVISIONS

A. DISCLOSURE AUTHORIZATION. In consideration of the Insurer's having waived physical examination in connection with the application herefor, the employee on behalf of himself and his covered dependents and sponsored dependents shall be deemed to have authorized any provider to make available to the Insurer information relating to all prescription orders, copies thereof and other records as needed by the Insurer.

B. The Insurer shall not be liable for any claim or demand for injuries or damage arising out of or in connection with the manufacturing, compounding, dispensing or use of any Prescription Legend Drugs or insulin, whether or not covered under this supplement.

C. The Insurer reserves the right to deny benefits for any drug prescribed or dispensed in a manner contrary to normal medical or pharmaceutical practice.

PARTICIPATING DRUG PHARMACY AGREEMENT (ATTACHED AS "EXHIBIT B" TO AFFIDAVIT OF STEVE G. McDONALD, FEBRUARY 23, 1976)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

PARTICIPATING DRUG PHARMACY AGREEMENT

between

GROUP LIFE & HEALTH INSURANCE COMPANY
(Herein called Blue Shield)
Dallas, Texas

and

_____

(Herein called the Participating Pharmacy)

_____

(Type of Organization)

_____

(Address)

Pharmacy Permit No. _____

1. The Participating Pharmacy agrees that all pharmacists dispensing drugs in its behalf are to be considered participating pharmacists. The pharmacists currently employed by the Participating Pharmacy are:

Name	License No.
_____	_____
_____	_____
_____	_____

2. The Participating Pharmacy shall dispense drugs for which benefits are provided under Blue Shield's Drug Supplement CC-OHDS-2 or any other supplement or contract upon written notice by Blue Shield, to persons who are entitled to benefits under such supplements, all in accordance with the terms of such instruments.

3. The Participating Pharmacy agrees to accept as full payment for each drug provided under Section 2, above, of this agreement an amount equal to the total of the acquisition cost for such drug and a professional dispensing fee of $————. Acquisition cost, as used in this agreement, means the actual cost of a drug to the Participating Pharmacy, as determined under rules and regulations published by Blue Shield.

4. Blue Shield agrees to pay to the Participating Pharmacy for each drug dispensed under Section 2 of this agreement an amount equal to the excess, if any, of the amount stipulated in Section 3, above, of this agreement over the drug deductible amount, if any, stipulated in the instrument under which drug benefits are available, and the Participating Pharmacy agrees that its charge for such drug to any other person shall not exceed such drug deductible.

5. Blue Shield agrees to provide the Participating Pharmacy with a manual which will stipulate the drugs for which benefits are available and drug deductible applicable to each person to whom drugs are to be dispensed under Section 2 of this agreement, and in which identification codes for certain of the drugs for which benefits are provided will be stipulated. The Participating Pharmacy agrees to include on those claims for benefits the code for the drug for which

claim is made if such code is shown in the Participating Pharmacy's current manual.

6. All contracts or transactions in which the Participating Pharmacy engages involving dispensing of drugs shall be between the Participating Pharmacy and the patient and Blue Shield shall not be a party thereto.

7. The Participating Pharmacy agrees that Blue Shield shall have the right to inspect all records pertaining to persons eligible for benefits under its drug supplements at any time during regular business hours.

8. The Participating Pharmacy agrees not to engage in any advertising relative to Blue Shield drug supplements without prior approval of Blue Shield.

9. This agreement may be terminated at any time by either party by giving at least 15 days prior written notice to the other party.

GROUP LIFE & HEALTH INSURANCE COMPANY

Dated at Dallas, Texas this

——day of————, 19—. By————————
President

————————

Dated at ————, Texas this

——day of————, 19—. By————————
Title:

LETTER OF TRANSMITTAL OF POLICY AND AGREEMENT TO STATE BOARD OF INSURANCE, DATED MARCH 14, 1969 (ATTACHED AS "EXHIBIT C" TO AFFIDAVIT OF STEVE G. McDONALD, FEBRUARY 23, 1976)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

GROUP LIFE & HEALTH
Insurance Company

[LOGO]

March 14, 1969

Mr. Robert C. McAnelly
Supervisor, AHGL Policy Unit
State Board of Insurance
1110 San Jacinto
Austin, Texas 78701

Re: Form No. CC-OHDS-2
Form No. PDPA-1

Dear Mr. McAnelly:

We submit herewith for your approval Form No. CC-OHDS-2 which is a Drug Supplement to our Custom Coverage Group Medical-Surgical Insurance Policy, Form No. MSCC-1, which was approved by your department under Order No. 19427 on 9-27-65. We will use application Form No. MSCC-App. 1, which was approved under the same order number.

I am also enclosing Form PDPA-1 which is the Participating Drug Pharmacy Agreement that Group Life & Health Insurance Company will enter into with pharmacies for the provision of benefits under this supplement.

Letter of Transmittal of Policy and Agreement

I am enclosing a duplicate copy of the supplement and agreement together with this letter in order that you may stamp them and return to us.

If we can furnish additional information concerning these filings, please advise.

Sincerely yours,

GROUP LIFE & HEALTH
INSURANCE COMPANY

/s/ Steve G. McDonald
STEVE G. McDONALD

[Disapproved By Order No. 29701, Jun. 18, 1969,
Commissioner of Insurance, State of Texas]

OFFICIAL ORDER NO. 29701 OF TEXAS COMMISSIONER OF INSURANCE, JUNE 18, 1969 (ATTACHED AS "EXHIBIT D" TO AFFIDAVIT OF STEVE G. McDONALD, FEBRUARY 23, 1976)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

No. 29701

OFFICIAL ORDER
of the
COMMISSIONER OF INSURANCE
of the
STATE OF TEXAS
AUSTIN, TEXAS

Date June 18, 1969

Subject Considered:

APPROVAL OF FORMS

General remarks and official action taken:

On this date came on for consideration by the Commissioner of Insurance application for approval of Form No. CC-OHDS-2 filed by Group Life & Health Insurance Company and the Commissioner, having found that said form does not comply with the requirements of Article 3.42, Texas Insurance Code, as amended, hereby disapproves said form under authority of the cited statute, and herenow states his grounds for such disapproval as follows:

Under provision of said form the differentiation of benefits as between "participating provider" dispensed drugs and "non-participating provider" dispensed drugs constitutes unfair discrimination within the meaning of Article 21.21, Texas Insurance Code.

Official Order No. 29701 of Texas Commissioner of Ins.

The provisions of said form are violative of the anti-trust and monopoly statutes of this state.

Prepared, recommended and approved by:

/s/ R. C. McAnelly
R. C. McANELLY, Supervisor
Health and Group Life Policy Unit
Life Division

COMMISSIONER OF INSURANCE

By /s/ Don B. Odum
DON B. ODUM
Section Manager
Life Division

OFFICIAL ORDER NO. 30413 OF TEXAS COMMISSIONER OF INSURANCE, DATED SEPTEMBER 30, 1969 (ATTACHED AS "EXHIBIT E" TO AFFIDAVIT OF STEVE G. McDONALD, FEBRUARY 23, 1976)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

No. 30413

OFFICIAL ORDER
of the
COMMISSIONER OF INSURANCE
of the
STATE OF TEXAS
AUSTIN, TEXAS

Date Sep. 30, 1969

Subject Considered:

POLICY FORM APPROVAL—

EXEMPTION FROM THE REQUIREMENTS OF ARTICLE 3.42, TEXAS INSURANCE CODE

General remarks and official action taken:

Pursuant to the authority granted by Article 3.42, Paragraph (e) of the Texas Insurance Code, the Commissioner of Insurance hereby exempts from the requirements of said Article Policy Form CC-OHDS-2 submitted by Group Life and Health Insurance Company, Dallas, Texas; and this exemption shall remain effective pending further orders from the Commissioner of Insurance. To the extent that this exemption order conflicts with Commissioner's Order No. 29701, dated June 18, 1969, Order No. 29701 is superseded.

This exemption order shall also apply to any form, identical in content to Form CC-OHDS-2, delivered, issued or used in this state by any licensed insurer.

This exemption order is issued and published for the reason that, in the opinion of the Commissioner, Article 3.42 of the Texas Insurance Code may not practicably be applied at this time to the forms covered by the exemption. The exempt forms are described as drug service contracts, which confer upon the policyholder the right to obtain certain prescribed drugs at a cost fixed in the contract, the insurer having entered into participating agreements with dispensing pharmacies to supply the prescribed drugs to its policyholders.

The policy forms herein exempt, used in connection with the participating agreements with pharmacies as described above, have raised questions under the Texas anti-trust and anti-monopoly laws, and such questions have been referred to the Attorney General of the State of Texas. Pending such time as these questions are resolved, the exemptions authorized by this Order are granted for the purpose of preventing any competitive advantages which foreign insurance companies, issuing policies outside of Texas but including Texas residents under their coverage, might have over domestic companies seeking to issue equivalent policy contracts.

/s/ Clay Cotten
CLAY COTTEN
Commissioner of Insurance

Prepared by:

/s/ Paul D. Connor
PAUL D. CONNOR
Assistant to the Commissioner

GROUP LIFE AND HEALTH INSURANCE COMPANY DRUG SUPPLEMENT POLICY, DATED OCTOBER 1, 1974 (ATTACHED AS "EXHIBIT F" TO AFFIDAVIT OF STEVE G. McDONALD, FEBRUARY 23, 1976)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

[LOGO]

GROUP LIFE & HEALTH INSURANCE CO.
(Herein called Blue Shield of Texas)

Dallas, Texas

has issued this

DRUG SUPPLEMENT

to the

EXPERIENCE RATED GROUP HOSPITALIZATION AND MEDICAL-SURGICAL CONTRACT

NO. 34567

issued heretofore or simultaneously herewith, to

ABC COMPANY
(therewith and herein called the Employer)

as of October 1, 1974 (herein called the supplemental contract date) and thereby agrees to provide the additional benefits detailed herein,

all in accordance with the conditions and provisions hereof, including those set out on the following pages which are a part of this supplement as fully as if recited over the signatures hereto affixed.

This supplement becomes effective on the supplemental contract date, and is issued in consideration of the appli-

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

cation herefor made by the Employer. It will be continued in force subject to the timely payment of premiums herefor, until terminated in accordance with the provisions of the Article captioned "Termination of Drug Coverage."

IN WITNESS WHEREOF, Blue Shield of Texas has caused this supplement to be executed at its Home Office in Dallas, Texas.

/s/ Tom L. Beauchamp, Jr.
President

/s/ [Illegible]
Secretary

Countersigned:

Registrar

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

ARTICLE I—SUPPLEMENTAL DEFINITIONS

AS USED HEREIN:

A. BASIC CONTRACT means the "Experience Rated Group Hospitalization and Medical-Surgical Contract" described on the face page hereof.

B. BASIC COVERAGE means the total amount of protection afforded a participant by the basic contract on account of expense incurred for drugs and medicines.

C. COVERED DRUGS means any Prescription Legend Drug or injectable insulin:

(1) which is ordered by a physician;

(2) for which a written prescription order is customarily prepared;

(3) for which a separate charge is customarily made;

(4) which is not entirely consumed at the time and place that the prescription order is written; and

(5) which is received by the participant while covered hereunder.

D. PRESCRIPTION LEGEND DRUG means any medicinal substance—the label of which, under the Federal Food, Drug, and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription."

E. DRUG DEDUCTIBLE means the amount to be paid by a participant toward the cost of the initial purchase of each covered drug and toward the cost of each refill purchase of each covered drug and for each such purchase and is equal to two dollars ($2.00).

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

F. PRESCRIPTION ORDER means a request for medication by a physician.

G. PHARMACY means a licensed establishment where Prescription Legend Drugs are dispensed by a person who is not a practitioner of the healing arts and who is licensed to dispense such drugs under the laws of the state in which he practices.

H. PROVIDER means any pharmacy, physician, or any other person or organization legally licensed to dispense drugs.

I. PARTICIPATING PROVIDER means a provider located in the State of Texas with which Blue Shield of Texas or Group Hospital Service, Inc. of Dallas, Texas, has entered into a written contract for the rendition of covered drugs for which benefits are provided by this supplement, or any provider located outside the State of Texas with which any other Blue Cross or Blue Shield Plan has entered into such a contract.

J. NON-PARTICIPATING PROVIDER means a provider who is not a participating provider.

ARTICLE II—TERMS AND PROVISIONS

A. All definitions, limitations, and provisions recited in the basic contract are hereby adopted and shall be construed to apply in like manner and with equal force to this supplement and any other provisions

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

insofar as they are in conflict with provisions herein contained, in which case the provisions of this supplement shall govern in any interpretation of rights or obligations accruing hereunder.

B. It is hereby specially declared that the non-duplication provisions set forth in Article V, Section E, of the basic contract are applicable to this supplement except insofar as they are modified by the provisions of the following subsections:

1. Determination of drug benefits under this supplement shall be made in relation to each "claim," consisting of any combination of charges for covered drugs which are incurred within a calendar year and submitted at one time by or on behalf of a participant to Blue Shield of Texas at his request for payment of drug benefits applicable thereto.

2. When the non-duplication provisions are applicable, the benefits of the other coverage and all benefits provided under the basic coverage on the items composing the claim shall be deducted from the charges for all such items, and Blue Shield of Texas will pay the remainder; provided, however, that in no event shall these provisions be construed to increase the amount of total benefits which would be payable under this supplement on account of such claim in the absence of other coverage.

ARTICLE III—BENEFITS

A. Subject to the exclusions, limitations, and all other terms and provisions set forth herein, any participant

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

shall be entitled to receive covered drugs from any participating provider as a benefit hereunder and shall be required to pay no more than the drug deductible for each of such covered drugs.

B. Any participant receiving covered drugs from a non-participating provider shall be entitled to benefits equal to 75% of the result of the reasonable charge for such covered drugs as determined by Blue Shield of Texas, reduced by the drug deductible for such covered drugs; except that for covered drugs received from a non-participating provider located outside of the State of Texas, such participant shall be entitled to benefits equal to 100% of the reasonable charge for such covered drugs, reduced by the drug deductible for each such covered drugs.

C. Payment of benefits by Blue Shield of Texas to the provider or to the employee, as Blue Shield of Texas may elect, shall constitute full discharge of all responsibility of Blue Shield of Texas to the employee on account of care rendered to any participant under his coverage.

ARTICLE IV—LIMITATIONS AND EXCLUSIONS

In addition to the limitations and exclusions stipulated in Article VIII of the basic contract, it is provided that no drug benefit shall be available for any of the following:

A. Any charge for a contraceptive medication, even if such medication is a Prescription Legend Drug, and any charge for therapeutic devices or appliances (including but not by way of limitation, hypodermic needles, syringes, support garments, and other non-medicinal substances) regardless of their intended use;

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

B. Any charge for services other than Covered Drugs, including administration of a Prescription Legend Drug or injectable insulin;

C. The charge for more than a 34-day supply of a medication, except that Blue Shield of Texas will cover 100 unit doses (e.g. tablet or capsule) of a natural thyroid product and 100 unit doses of nitroglycerine;

D. The charge for any prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from the physician's order;

E. Covered Drugs for which no charge is customarily made;

F. Covered Drugs to the extent that a benefit is provided therefor under the basic coverage;

G. Covered Drugs which are not medically necessary.

ARTICLE V—TERMINATION OF DRUG COVERAGE

A. This supplement and coverage of all participants hereunder shall automatically terminate:

1. When the basic contract is terminated for any reason;
2. Upon default in payment of supplemental premiums, subject to the grace period and reinstatement provided for in the basic contract;
3. Upon cancellation of this supplement in any manner as specified in the basic contract for cancellation thereof.

B. The coverage of any participant under this supplement shall automatically terminate when his coverage under the basic contract is terminated, subject, however, to refund of supplemental premiums paid in advance, as therein provided.

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

C. Under no circumstances shall Blue Shield of Texas be obligated to notify any participant of the termination of this supplement or of his coverage hereunder.

D. No conversion privilege afforded a participant under the basic contract shall be deemed to apply to this supplement.

ARTICLE VI—GENERAL PROVISIONS

A. DISCLOSURE AUTHORIZATION. In consideration of Blue Shield of Texas having waived a physical examination in connection with the application herefor, the employee on behalf of himself and his covered dependents shall be deemed to have authorized any provider to make available to Blue Shield of Texas information relating to all prescription orders, copies thereof and other records as needed by Blue Shield of Texas.

B. Blue Shield of Texas shall not be liable for any claim or demand for injuries or damage arising out of or in connection with the manufacturing, compounding, dispensing or use of any Prescription Legend Drug or insulin, whether or not covered under this supplement.

C. Blue Shield of Texas reserves the right to deny benefits for any drug prescribed or dispensed in a manner contrary to normal medical or pharmaceutical practice.

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

LETTER OF TRANSMITTAL OF POLICY TO STATE BOARD OF INSURANCE, DATED SEPTEMBER 23, 1974 (ATTACHED AS "EXHIBIT G" TO AFFIDAVIT OF STEVE G. McDONALD, FEBRUARY 23, 1976)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

GROUP LIFE & HEALTH
Insurance Company

[LOGO]

Main at North Central Expressway
P. O. Box 5403
Dallas, Texas 75222

September 23, 1974

Mr. A. W. Pogue, Manager
Headquarters Section, Life Division
State Board of Insurance
1110 San Jacinto
Austin, Texas 78786

Re: MF-1, Experience Rated Group Hospitalization and Medical-Surgical Contract
MF-1-DS-1, Drug Supplement
MF-1-APP-1, Group Application Blank
MF-1-OA-1, Operating Agreement
MF-1-IA-1, Insurance Agreement

Dear Mr. Pogue:

We submit herewith for your approval the above described new contract forms.

We anticipate entering into a health care program agreement with the Bexar County Medical Foundation wherein

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

Letter of Transmittal of Policy

Blue Shield of Texas will provide benefits as set forth in Form Nos. MF-1, Article VII, and MF-1-DS-1 to groups desiring this coverage. The Bexar County Medical Foundation will provide medical-surgical benefits as set forth in a separate contract, a copy of which will be sent to you in a few days for information purposes only.

We are also submitting for your approval the operating and reinsurance agreements between Blue Cross and Blue Shield of Texas and the Bexar County Medical Foundation. The attached list indicates our internal stock control numbers used for these various forms.

Within the next few weeks we will submit the certificate-booklet and enrollment application card for your approval.

We are submitting two copies of each form described above, together with an extra copy of this letter. Will you please stamp the extra copy of each "approved" and return to us for our files. These same forms are being concurrently filed by Group Hospital Service, Inc.

If additional information is needed regarding this filing, please call me in order that we may discuss the matter more in detail by telephone.

Yours very truly,

GROUP LIFE & HEALTH
INSURANCE CO.

/s/ Steve G. McDonald
STEVE G. McDONALD

SGMcD:jc

Encs.

cc: Mr. Joe Hawkins, Mr. John Holden

Letter of Transmittal of Policy

MF-1, Experience Rated Group Hospitalization and Medical-Surgical Contract (between Blue Cross and Blue Shield and the Group)

1600-974	Face Page	
1601-974	Article I	
1602-974	Article I	(Page 2)
1603-974	Article I	(Page 3)
1604-974	Article I	(Page 4)
1605-974	Article II	
1606-974	Article II	(Page 2)
1607-974	Article II	(Page 3)
1608-974	Article III	
1609-974	Article IV	
1610-974	Article IV	(Page 2)
1611-974	Article V	
1612-974	Article V	(Page 2)
1613-974	Article V	(Page 3)
1618-974	Article VII	
1619-974	Article VII	(Page 2)
1620-974	Article VII	(Page 3)
1621-974	Article VIII	
1622-974	Article VIII	(Page 2)
1623-974	Article IX	
1624-974	Article IX	(Page 2)
1625-974	Article X	
1626-974	Article XI	
1627-974	Article XI	(Page 2)
1628-974	Article XI	(Page 3)

MF-1-DS-1, Drug Supplement

1629-974	Face Page
1630-974	Article I
1631-974	Article II
1632-974	Article III
1633-974	Article IV
1634-974	Article V
1635-974	Article VI

MF-1-APP-1, Group Application Blank

1636-974	Page 1
1637-974	Page 2

OFFICIAL ORDER NO. 45511 OF TEXAS COMMISSIONER OF INSURANCE, DATED OCTOBER 1, 1974 (ATTACHED AS "EXHIBIT H" TO AFFIDAVIT OF STEVE G. McDONALD, FEBRUARY 23, 1976)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

No. 45511

OFFICIAL ORDER
of the
COMMISSIONER OF INSURANCE
of the
STATE OF TEXAS
AUSTIN, TEXAS

Date Oct. 1, 1974

Subject Considered:

General remarks and official action taken:

On this date came on for consideration by the Commissioner of Insurance applications for approval of the forms described herein; and the Commissioner, having found that each of said forms complies with the requirements of Article 3.42, Texas Insurance Code, as amended, hereby approves each of said forms under authority of the cited statute:

Submitted By:	Identifying Form Nos.:
Group Hospital Service, Inc. Group Life & Health Insurance Company	MF-1 with; MF-1-APP-1 attached; MF-1-DS-1.

This approval is extended for use as the insurer portion of a Group Comprehensive Medical Care Plan and such approval is limited and does not constitute approval of the said form for any other use under the Texas Insurance Code.

Official Order No. 45511 of Texas Commissioner of Ins.

/s/ Don B. Odum
DON B. ODUM
COMMISSIONER OF INSURANCE

Prepared, recommended and approved by:

/s/ Mildred R. Kurt
(MRS.) MILDRED R. KURT, Supervisor
Health and Group Life Policy Unit
Life Division

MOTION OF DEFENDANT WALGREEN TEXAS CO. TO DISMISS, FEBRUARY 23, 1976

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

MOTION OF DEFENDANT, WALGREEN TEXAS CO., TO DISMISS

Defendant, WALGREEN TEXAS CO., respectfully moves the Court to dismiss Plaintiffs' Original Complaint pursuant to Rules 12(b) and 56, Federal Rules of Civil Procedure.

1.

This Motion is based on the specific grounds that this Court lacks jurisdiction over the subject matter of the Complaint, all as set out and detailed in the Motion To Dismiss of the principal Defendant, GROUP LIFE AND HEALTH INSURANCE COMPANY, and which grounds are hereby adopted in full by Defendant, WALGREEN TEXAS CO.

2.

Defendant, WALGREEN TEXAS CO., in support of this Motion to Dismiss, would adopt in full the argument and authorities as contained in the Memorandum Brief filed herein by the principal Defendant, GROUP LIFE AND HEALTH INSURANCE COMPANY.

WHEREFORE, WALGREEN TEXAS CO., prays that this Court dismiss Plaintiffs' Original Complaint or that this Motion be treated as one for Summary Judgment.

Respectfully submitted,

/s/ Wm. C. Church, Jr.
WM. C. CHURCH, JR.
8700 Tesoro Drive
Suite #120
Post Office Box 17409
San Antonio, Texas 78217
(512) 828-8261

Attorney for Defendant,
Walgreen Texas Co.

Of Counsel:

KAMPMANN, CHURCH & BURNS
8700 Tesoro Drive
Suite #120
Post Office Box 17409
San Antonio, Texas 78217

CERTIFICATE OF SERVICE

I certify a true and correct copy of the above and foregoing Motion of Defendant, WALGREEN TEXAS CO., To Dismiss, was mailed, postage prepaid, to the following counsel of record, this 23rd day of February, 1976:

Mr. Joel H. Pullen
TINSMAN & HOUSER, INC.
1900 National Bank of Commerce Building
San Antonio, Texas 78205
Attorneys for Plaintiffs

Mr. Keith E. Kaiser
COX, SMITH, SMITH, HALE & GUENTHER, INC.
500 National Bank of Commerce Building
San Antonio, Texas 78205
Attorneys for Defendant,
Group Life and Health Insurance Company

Mr. Charles R. Shaddox
GROCE, LOCKE & HEBDON
200 Frost Bank Tower
San Antonio, Texas 78205
Attorneys for Defendant,
Rieger/Medi-Save Pharmacies, Inc.

MOTION OF DEFENDANT THE SOMMERS DRUG STORES COMPANY TO DISMISS, FEBRUARY 23, 1976

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

MOTION OF DEFENDANT, THE SOMMERS DRUG STORES COMPANY, TO DISMISS

Comes now Defendant, THE SOMMERS DRUG STORES COMPANY ("Sommers"), and files this its Motion to Dismiss and says:

1. The grounds for dismissal set forth in the MOTION OF DEFENDANT, GROUP LIFE AND HEALTH INSURANCE COMPANY ("Blue Shield") and the arguments contained in the accompanying Blue Shield Brief clearly show that the case should be dismissed against Sommers.

2. Sommers reiterates its defenses set forth as Sommers' THIRD DEFENSE in Sommers' Answer, heretofore filed in this cause, and moves the Court to dismiss this cause based upon such allegations, which are as follows:

Third Defense

The Complaint fails to state a claim upon which relief can be granted against Sommers under the antitrust laws of the United States because the Defendant GROUP LIFE AND HEALTH INSURANCE COMPANY ("Blue Cross") is engaged in the "business of insurance", and all matters alleged by Plaintiffs herein arise out of the "business of insurance", which is regulated by the Insurance Commissioner of the State of Texas and exempt

from the provisions of the Sherman and Clayton Acts pursuant to the McCarran-Ferguson Act (15 U.S.C. § 1011, *et seq.*).

3. Sommers joins Blue Shield in its Motion Number 4 to Treat Blue Shield Motion as one for summary judgment and adopts said Motion and supporting documentation.

4. This Motion is supported by the Sommers Brief filed contemporaneously herewith.

WHEREFORE, Sommers prays that this honorable court dismiss Plaintiff's Original Complaint and that this Motion be treated as one for summary judgment.

Respectfully submitted,

GRESHAM, DAVIS, GREGORY,
WORTHY & MOORE
1800 Frost Bank Tower
San Antonio, Texas 78205

By /s/ Richard B. Moore
RICHARD B. MOORE

[Certificate of Service Omitted in Printing]

MOTION OF DEFENDANT RIEGER/MEDI-SAVE PHARMACIES, INC. TO DISMISS, FEBRUARY 25, 1976

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

DEFENDANT, RIEGER-MEDI-SAVE PHARMACIES, INC.'S MOTION TO DISMISS

TO THE HONORABLE UNITED STATES DISTRICT COURT:

NOW COMES Defendant, RIEGER-MEDI-SAVE PHARMACIES, INC., and files its Motion to Dismiss, and for alternative relief, and would show the Court as follows:

I.

In support of this Motion, Defendant relies upon the pleadings on file and such depositions and affidavits which shall be timely filed in connection with the Motion.

II.

Defendant, RIEGER-MEDI-SAVE PHARMACIES, INC., hereby incorporates by reference, the Motion to Dismiss of Defendant Group Life and Health Insurance Company, together with the Brief filed in support of that Motion. Defendant RIEGER-MEDI-SAVE PHARMACIES, INC., asks the Court to consider all matters raised in that Motion and Brief in connection with this Motion.

Motion of Defendant Rieger/Medi-Save to Dismiss

III.

This Defendant moves the Court pursuant to Rule 12(b), to dismiss Plaintiff's Complaint for lack of jurisdiction over the subject matter and failure to state a claim upon which relief may be granted. Defendant alternatively asks the Court to treat this Motion as one for Partial Summary Judgment, pursuant to Rule 56 of the Federal Rules of Civil Procedure, and grant it Judgment on all Federal Anti-Trust Claims asserted by Plaintiffs.

As grounds for such relief this Defendant would show the Court that all matters raised by Plaintiff's Complaint (except the purely pendent count) have been exempted from the application of the Sherman and Clayton Acts (15 U.S.C. Sections 1 to 7; 15 U.S.C. Section 12, et seq.) by the application of the McCarran-Ferguson Act (15 U.S.C. Section 1011, et seq.). Since the McCarran-Ferguson Act removes the complained of activities from the Sherman and Clayton Acts, there is no statutory basis to support this action. The Original Complaint on its face [indicates] that there is no total diversity of citizenship between the parties.

As there is no original jurisdiction for this action, the remaining pendant counts should likewise be dismissed.

Defendant, RIEGER-MEDI-SAVE PHARMACIES, INC., moves the Court to Dismiss the Complaint or, alternatively, grant it a Summary Judgment on all Federal Anti-Trust Claims, and to dismiss the remaining pendant count.

Motion of Defendant Rieger/Medi-Save to Dismiss

Respectfully submitted,

GROCE, LOCKE & HEBDON

By: /s/ Charles R. Shaddox
CHARLES R. SHADDOX
2000 Frost Bank Tower
San Antonio, Texas 78205

Attorneys for Defendant,
Rieger-Medi-Save
Pharmacies, Inc.

[Certificate of Service Omitted in Printing]

STIPULATION OF PLAINTIFFS AND DEFENDANT RIEGER/MEDI-SAVE PHARMACIES, INC., MARCH 11, 1976

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

STIPULATION

It is agreed by and between Plaintiffs and Defendant, RIEGER-MEDI-SAVE PHARMACIES, INC., that the following facts are stipulated for the purpose of the Motions to Dismiss filed by Defendants, February 20, 1976.

I.

RIEGER-MEDI-SAVE PHARMACIES, INC., operates three (3) retail pharmacies located in Gibson's Discount Centers, in Bexar County, Texas.

II.

RIEGER-MEDI-SAVE PHARMACIES, INC., has not been licensed by the State of Texas to issue policies of insurance.

III.

RIEGER-MEDI-SAVE PHARMACIES, INC., does not operate an insurance agency licensed pursuant to V.A.T.S., Insurance Code, Art. 21.07, et seq., or 21.14, et seq., in Bexar County, Texas.

Stipulation of Rieger/Medi-Save Pharmacies, Inc.

STIPULATED this 9th day of March, 1976.

/s/ C. R. Shaddox
CHARLES R. SHADDOX
2000 Frost Bank Tower
San Antonio, Texas 78205

Attorney for Defendant,
Rieger-Medi-Save
Pharmacies, Inc.

By: /s/ Joel H. Pullen
JOEL H. PULLEN
1900 National Bank of
Commerce Building
San Antonio, Texas 78205

Attorney for Plaintiffs

STIPULATION OF PLAINTIFFS AND DEFENDANT THE SOMMERS DRUG STORES COMPANY, MARCH 11, 1976

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

STIPULATION

It is agreed by and between Plaintiffs and Defendant, THE SOMMERS DRUG STORES COMPANY, that the following facts are stipulated for the purpose of the Motions to Dismiss filed by Defendants, February 20, 1976.

I.

THE SOMMERS DRUG STORES COMPANY operates twenty-five (25) retail pharmacies in Bexar County, Texas.

II.

THE SOMMERS DRUG STORES COMPANY has not been licensed by the State of Texas to issue policies of insurance.

III.

THE SOMMERS DRUG STORES COMPANY does not operate an insurance agency licensed pursuant to V.A.T.S., Insurance Code, Art. 21.07, et seq., or 21.14, et seq., in Bexar County, Texas.

Stipulation of The Sommers Drug Stores Co.

STIPULATED this 10th day of March, 1976.

/s/ Richard B. Moore
RICHARD B. MOORE
1800 Frost Bank Tower
San Antonio, Texas 78205

Attorney for Defendant,
The Sommers Drug Stores
Company

By /s/ Joel H. Pullen
JOEL H. PULLEN
1900 National Bank of
Commerce Building
San Antonio, Texas 78205

Attorney for Plaintiffs

STIPULATION OF PLAINTIFFS AND DEFENDANT WALGREEN TEXAS CO., MARCH 11, 1976

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

STIPULATION

It is agreed by and between Plaintiffs and Defendant, WALGREEN TEXAS CO., that the following facts are stipulated for the purpose of the Motions to Dismiss filed by Defendants.

1.

Defendant, WALGREEN TEXAS CO., operates two (2) retail pharmacies located in San Antonio, Bexar County, Texas.

2.

Defendant, WALGREEN TEXAS CO., has not been licensed by the State of Texas to issue policies of insurance.

3.

Defendant, WALGREEN TEXAS CO., does not operate an insurance agency licensed pursuant to V.A.T.S., Insurance Code, Art. 21.07, et. seq., or 21.14, et. seq., in San Antonio, Bexar County, Texas.

Stipulation of Walgreen Texas Co.

STIPULATED this 11th day of March, 1976.

/s/ Wm. C. Church, Jr.
WM. C. CHURCH, JR.
8700 Tesoro Drive,
Suite #120
San Antonio, Texas 78217
Attorney for Defendant,
Walgreen Texas Co.

/s/ Joel H. Pullen
JOEL H. PULLEN
1900 National Bank of
Commerce Building
San Antonio, Texas 78205
Attorney for Plaintiffs

AFFIDAVIT OF BRUCE L. BUSBY IN SUPPORT OF DEFENDANT RIEGER/MEDI-SAVE PHARMACIES, INC.'S MOTION TO DISMISS, APRIL 19, 1976

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

AFFIDAVIT IN SUPPORT OF DEFENDANT RIEGER/MEDI-SAVE PHARMACIES, INC.'s MOTION TO DISMISS

BRUCE L. BUSBY, herein states and deposes as follows:

1. I am Bruce L. Busby, an adult resident of East Baton Rouge Parish, Louisiana, possessed of sound mind and I have never been convicted of a felony. I am competent to testify about the matters contained herein and this statement is based on my personal knowledge.

2. I hold the position of treasurer at Rieger/Medi-Save Pharmacies, Inc. (now Medi-Save Pharmacies, Inc.), which position I have held for more than six (6) years; I have also been vice-president for approximately one year. My responsibilities include supervision of all finance functions and accounting and control functions.

3. The only contracts known to me between any representative of Rieger/Medi-Save Pharmacies, Inc. and any representative of Group Life and Health Insurance Company are as follows: Rieger/Medi-Save Pharmacies, Inc. received copies of Group Life and Health Insurance Company's participating drug pharmacy agreement in the mail. Rieger/Medi-Save Pharmacies, Inc. then informed Group Life and Health Insurance Company that it wished to participate in the program and requested further in-

formation concerning the administrative details and processing claims. Each of the Rieger/Medi-Save Pharmacies, Inc. stores which were to participate executed a contract, as did Rieger/Medi-Save Pharmacies, Inc. Since the execution of the initial contracts, the only further contacts between Rieger/Medi-Save Pharmacies, Inc. and Group Life and Health Insurance Company have consisted solely of correspondence regarding claims between the individual stores and Group Life and Health Insurance Co. I do not know of any correspondence directly between Rieger/Medi-Save Pharmacies, Inc. and Group Life and Health Insurance Co. since execution of the initial contracts, other than correspondence attached as Exhibit A.

4. Rieger/Medi-Save Pharmacies, Inc. has never contacted any Walgreen's Texas stores or any Sommers Drug Stores with regard to Group Life and Health Insurance Company's participating drug pharmacy agreement, the setting or fixing of the retail price of prescription pharmaceuticals, or the foreclosure of any of the plaintiffs from any portion of the market for prescription pharmaceuticals.

5. At no time has Rieger/Medi-Save Pharmacies, Inc. or any of its directors, officers, employees, or agents taken any action designed to foreclose any of the plaintiffs in this cause from any portion of the market for prescription pharmaceuticals.

6. Rieger/Medi-Save Pharmacies, Inc., its officers, directors, employees and agents have never conspired with, consulted with, or even considered the actions of any of the defendants in this case in determining the retail price of prescription pharmaceuticals.

/s/ Bruce L. Busby
BRUCE L. BUSBY

STATE OF LOUISIANA

PARISH OF EAST BATON ROUGE

SWORN TO AND SUBSCRIBED BEFORE ME, a notary public, on this the 15th day of April, 1976.

/s/ William D. Morgan
WILLIAM D. MORGAN,
Notary Public

My Commission expires at death.

[Certificate of Service Omitted in Printing]

AFFIDAVIT OF JOHN HANNAH, APRIL 19, 1976

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

[Caption Omitted in Printing]

AFFIDAVIT

JOHN HANNAH, by me being first duly sworn, deposes and says:

1. That he is a duly elected, qualified and acting Vice President of THE SOMMERS DRUG STORES COMPANY, (Sommers) a corporation duly organized under the laws of Maryland, and existing, and authorized to do business under and by virtue of the laws of the State of Texas, with its principal place of business in the City of San Antonio, Bexar County, Texas, and one of the Defendants in this cause.

2. That the relationship between Blue Shield and Sommers originated with a submission from Blue Shield in November, 1974, of a proposed form of Participating Pharmacy Agreement, which was considered by Sommers without discussion with any other person, firm, or entity, and the Sommers' decision to accept the Participating Pharmacy Agreement was made unilaterally by Sommers.

3. That at no time in making this decision whether to accept the offered Blue Shield contract was Sommers contacted by any representative of any other drug store defendant in this case.

4. That Sommers has never combined and conspired with any of the other Defendants in this cause, or with

any other person, firm or entity, to fix the retail sales price for pharmaceuticals or any other goods.

/s/ John Hannah
JOHN HANNAH

SWORN TO and SUBSCRIBED before me this 16th day of April, 1976.

/s/ Katharine Nellis
KATHARINE NELLIS
Notary Public in and for
Bexar County, Texas

OPINION OF UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF TEXAS, MAY 18, 1976

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

Civil Action No. SA-75-CA-131

ROYAL DRUG COMPANY d/b/a Royal Pharmacy of Castle Hills and Disco Prescription Pharmacy, et al.

v.

GROUP LIFE AND HEALTH INSURANCE COMPANY a/k/a Blue Shield and/or Blue Cross-Blue Shield of Texas, et al.

June 23, 1976

Joel H. Pullen, Tinsman & Houser, Inc., San Antonio, Tex., for plaintiffs.

Keith E. Kaiser, Cox, Smith, Smith, Hale & Guenther, Inc., San Antonio, Tex., for Group Life and Health Ins. Co.

Charles R. Shaddox, Groce, Locke & Hebdon, San Antonio, Tex., for Rieger/Medi-Save Pharmacies, Inc.

William C. Church, Jr., Kampmann, Church & Burns, San Antonio, Tex., for Walgreen Texas Co.

Richard B. Moore, Gresham, Davis, Gregory, Worthy & Moore, San Antonio, Tex., for The Sommers Drug Stores Co.

MEMORANDUM OPINION

JOHN H. WOOD, JR., *District Judge.*

I.

Plaintiffs in this private civil antitrust action are eighteen independent pharmacy owners doing business in San

Antonio, Texas. Defendant Group Life and Health Insurance Company, also known as Blue Shield of Texas ("Blue Shield"), is an insurance company duly authorized by the Texas State Board of Insurance to transact the business of life, health and accident insurance within the State of Texas. The remaining three Defendants, Walgreen Texas Co. ("Walgreen"), The Sommers Drug Stores Company ("Sommers"), and Rieger/Medi-Save Pharmacies, Inc. ("Rieger") operate pharmacies in San Antonio, Texas.

Plaintiffs' suit is an attack upon Blue Shield's plan of operation under certain prescription drug insurance policies (the "Policy") which it issues. It is alleged that Defendants have violated Section 1 of the Sherman Act, 15 U.S.C. § 1, by agreeing, combining and conspiring to fix the retail price of drugs and pharmaceuticals, and that the activities of Defendants have caused Blue Shield's insureds not to deal with certain of the Plaintiffs, thereby constituting a group boycott. Plaintiffs further allege that Defendants have violated the Texas antitrust laws, Tex. Bus. & Comm. Code Ann. § 15.01, *et seq.*, and that this Court should exercise pendent jurisdiction over those claims.

Each of the Defendants has separately moved to dismiss the Complaint for lack of jurisdiction over the subject matter and for failure to state a claim upon which relief can be granted. Defendants' motions are based upon the provisions of the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.* The motions also urge that in the absence of any valid cause of action based upon federal law, this Court should dismiss Plaintiffs' pendent claims.

Extensive discovery has been completed on the issue presently before the Court. The record includes numerous depositions, affidavits and documents, and all parties have had full opportunity to present all materials pertinent to

Defendants' motions. The Court has carefully reviewed and considered all of those materials, together with the briefs submitted by the parties and the oral argument of counsel.

The facts relevant to Defendants' motions are undisputed. The Policies provide prescription drug insurance coverage. The benefits provided under the Policies entitle Blue Shield's insureds to receive prescription drugs from any pharmacy (a "Participating Pharmacy") that has entered into a written contract (the "Pharmacy Agreement") with Blue Shield. The Policies further provide that the insured is required to pay no more for each prescription filled by a Participating Pharmacy than the amount of the drug deductible set forth in the Policy. The drug deductible is $2.00. Pursuant to the terms of the Pharmacy Agreement, a Participating Pharmacy agrees to dispense drugs to Blue Shield's insureds and to accept $2.00 as full payment from the insured for each dispensed drug. Further, Blue Shield agrees to reimburse the Participating Pharmacy for the acquisition cost of each drug dispensed to its insureds. Under the terms of the Policy, if the insured has his prescriptions filled by a pharmacy other than a Participating Pharmacy, he must pay the full price charged by the pharmacy and then apply to Blue Shield for reimbursement. Blue Shield will then reimburse the insured for 75% of the usual and customary charge for the drug, less the $2.00 deductible.

Walgreen, Sommers and Rieger each own Participating Pharmacies. Blue Shield is not engaged in selling or dispensing prescription drugs as a manufacturer, wholesaler or retailer, but is engaged solely in transacting the business of life, health and accident insurance.

In 1969, Blue Shield sought authority from the Texas State Board of Insurance to begin issuing prescription drug insurance coverage in the form described above. Article 3.42 of the Texas Insurance Code provides that all new policy forms proposed to be issued by life, health and accident insurance companies must be filed with the State Board of Insurance and approved prior to issuance or use by the company. In March, 1969, Blue Shield filed with the State Board of Insurance a proposed form of the Policy and the Pharmacy Agreement for approval prior to their issuance or use. The terms of the policy provided that Blue Shield's insureds were entitled to receive prescription drugs from Participating Pharmacies (called "participating providers" in the Policy). The Policy defined the term "participating provider" as a pharmacy who "has entered into a written contract [with Blue Shield] for the rendition of covered drugs for which benefits are provided by this [policy]." The Pharmacy Agreement was in the form described above.

In June, 1969, the Commissioner of Insurance issued a written order disapproving the issuance or use of the Policy. The Commissioner also notified the Texas Attorney General in writing of the action taken by the State Board and provided the Attorney General with copies of all pertinent documents. As a result of the disapproval order, Blue Shield did not issue or use the Policy or the Pharmacy Agreement.

Subsequent to the issuance of the disapproval order, the Policy and the Pharmacy Agreement remained under consideration by the State Board of Insurance. In September, 1969, pursuant to Article 3.42(e) of the Texas Insurance Code,* the Commissioner of Insurance issued another writ-

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* "The Board of Insurance Commissioners may, by written order, exempt from the requirements of this Article for so long as it deems proper, any insurance document or form specified in such order to which in its opinion this Article may not practicably be applied, or the filing and approval of which are, in its opinion, not desirable or necessary for the protection of the public." Tex. Ins. Code Ann. art. 3.42(e).

ten order exempting the Policy from the approval requirements of Tex.Ins.Code Ann. art. 3.42.

The exemption order issued by the Commissioner of Insurance provided, in pertinent part:

> "Pursuant to the authority granted by Article 3.42, Paragraph (e) of the Texas Insurance Code, the Commissioner of Insurance hereby exempts from the requirements of said Article Policy Form CC-OHDS-2 submitted by Group Life and Health Insurance Company, Dallas, Texas; and this exemption shall remain effective pending further orders from the Commissioner of Insurance.
>
> "The exempt forms are described as drug service contracts, which confer upon the policy holder the right to obtain certain prescribed drugs at a cost fixed in the contract, the insurer having entered into participating agreements with dispensing pharmacies to supply the prescribed drugs to its policy holders."

It is clear that the exemption order exempted the Policy from nothing more than the requirement of approval by the State Board of Insurance. The former Deputy Commissioner of Insurance, who reviewed the Policy and the Pharmacy Agreement and then prepared the exemption order for the Commissioner's signature, testified on oral deposition that exempted policies are subject to all statutory requirements of the Texas Insurance Code and all regulatory requirements of the State Board of Insurance. He further testified that exempted policies and approved policies are subject to the same continuing regulation, control and supervision by the State Board. Other officials of the State Board of Insurance testified on oral deposition that exempted policies and approved policies are treated alike within the regulatory framework of the State Board of Insurance.

Further, the exemption order clearly shows that the Commissioner of Insurance considered the Pharmacy Agreement together with the Policy prior to issuing the exemption order. The exemption order authorized Blue Shield to issue and use the Policy in the State of Texas in the same manner as if it had been approved. Subsequent to the issuance of the exemption order, the Commissioner again advised the Texas Attorney General in writing of his action and forwarded a copy of the exemption order to the Attorney General. The exemption order has not been modified or rescinded.

Thereafter, Blue Shield made a statewide mailing to licensed pharmacies offering them the option of entering into the Pharmacy Agreement. Subsequent to the issuance of the exemption order, Blue Shield has issued the policy to various groups and entered into the Pharmacy Agreement with pharmacies throughout the State of Texas.

In 1974, Blue Shield entered into a health care agreement to provide insurance benefits to groups in Bexar County, Texas. Included in the proposed coverage was prescription drug insurance. In September, 1974, pursuant to Tex.Ins.Code Ann. art. 3.42, a Policy form virtually identical to the one submitted in 1969 was filed with the State Board of Insurance for approval prior to issuance or use in connection with the Bexar County program. Thereafter, in October, 1974, the Commissioner of Insurance issued a written order approving the Policy for issuance. Since receipt of the approval order, Blue Shield has issued the Policy to various groups in Bexar County, Texas. Blue Shield offered to virtually all licensed pharmacies in San Antonio, Texas, the opportunity of entering into a Pharmacy Agreement. Nine of the Plaintiffs accepted Blue Shield's offer and now operate Participating Pharmacies.

Plaintiffs agree that Blue Shield is engaged in the business of issuing prescription drug insurance coverage; however, they contend that the McCarran-Ferguson exemption is inapplicable in that Blue Shield has exceeded the business of insurance by entering into the Pharmacy Agreements, and that such agreements have nothing to do with the business of insurance. Plaintiffs further contend that regardless of whether or not Blue Shield is engaged in the business of insurance, Walgreen's, Sommers' and Rieger's participation in the Pharmacy Agreement is not the business of insurance.

For the reasons set forth herein, this Court does not agree with Plaintiffs' contentions. It is clear that the terms of the Policies which were reviewed by the State Board of Insurance and which it authorized Blue Shield to issue, expressly contemplate the execution of Pharmacy Agreements between Blue Shield and Participating Pharmacies. Moreover, the Pharmacy Agreement is so integrally related to the Policies that it would be impossible for Blue Shield to fulfill its contractual obligations to its insureds in the absence of such agreements.

The McCarran-Ferguson Act provides that ". . . the Sherman Act, . . . the Clayton Act, and the . . . Federal Trade Commission Act . . . shall be applicable to the business of insurance to the extent that such business is not regulated by State law." 15 U.S.C. § 1012(b). To the extent a state regulates such business by state law, the Sherman Act and the other federal antitrust laws are not applicable. The exemption is effective provided that two criteria are met: (1) that the "business of insurance" is involved, and (2) that there is state regulation of the business of insurance. The McCarran-Ferguson Act does not apply to acts of "boycott, coercion or intimidation." 15 U.S.C. § 1013(b).

II.

THE BUSINESS OF INSURANCE

In *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564, 21 L.Ed.2d 668 (1969), the Supreme Court held that the "business of insurance" includes the relationship between the insurer and insured; the type of policy which could be issued, its reliability, interpretation and enforcement; and other activities of insurance companies which closely relate to their status as reliable insurers. *Id.* at 460, 89 S.Ct. 564. The Pharmacy Agreement directly pertains to the relationship between Blue Shield and its insureds. Moreover, the Pharmacy Agreement is a *direct* contractual relationship between the insurer and a provider of benefits, the result of which is simply the performance of the insurer's obligations owed to its insureds under the insurance contract and nothing more. A similar *direct* contractual relationship was examined in *Travelers Ins. Co.* v. *Blue Cross of West. Pennsylvania*, 481 F.2d 80 (3rd Cir. 1973) *cert. denied*, 414 U.S. 1093, 94 S.Ct. 724, 38 L.Ed.2d 550 (1973). In that case, the Third Circuit held that such contractual arrangements constituted the business of insurance, and thus, the relationship fell within the McCarran-Ferguson exemption. Direct contractual relationships between the insurer and a provider of benefits, as in this case, plainly relate to the "relationship between insurer and insured." The Pharmacy Agreement is based upon the provisions contained in the Policies relating to coverage and benefits, and directly concerns matters of interpretation and enforcement of the Policies. Clearly, the method adopted by Blue Shield of providing benefits under the Policies is closely connected to the relationship between Blue Shield and its insureds. The activities challenged by Plaintiffs in this action, including Blue Shield's contractual arrange-

ments with Participating Pharmacies, constitute the business of insurance within the meaning of *SEC* v. *National Securities, Inc., supra.*

A program substantially similar in concept and operation to the one at issue was previously determined by the Texas Attorney General to constitute the business of insurance in the State of Texas. In response to a request for an opinion from the Texas Commissioner of Insurance, the Attorney General analyzed a prescription drug program which contemplated the filling of subscriber's prescriptions by participating pharmacies. The plan of operation was based upon a contract between the company and participating pharmacies, whereby the pharmacy agreed to charge the subscriber no more than a certain percentage of the retail price of the prescription, and the company agreed to reimburse the pharmacy for the remainder. After thoroughly discussing the program the Attorney General concluded that ". . . the plan of operation intended to be followed by Prepaid Prescription Plan, Inc. would involve the doing of an insurance business in this state". Texas Attorney General's Opinion No. WW-1475 (Dec. 11, 1962).

This Court concludes that Blue Shield's plan of operation under the prescription drug insurance Policies, including the Pharmacy Agreements, constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act.

III.

STATE REGULATION

A. *General Regulation.*

The McCarran-Ferguson Act renders the federal antitrust laws inapplicable when state legislation generally proscribes, permits, or otherwise regulates the conduct in

question and authorizes enforcement through a scheme of administrative supervision. *Crawford* v. *American Title Ins. Co.*, 518 F.2d 217 (5th Cir. 1975); *FTC* v. *National Cas. Co.*, 357 U.S. 560, 78 S.Ct. 1260, 2 L.Ed.2d 1540 (1958); *Commander Leasing Co.* v. *Transamerica Title Ins. Co.*, 477 F.2d 77 (10th Cir. 1973).

The State of Texas has actively regulated the activities challenged in Plaintiffs' Complaint since the inception of Blue Shield's prescription drug insurance program. The requirement of Article 3.42 of the Texas Insurance Code that all policy forms must be filed for review and approval by the State Board of Insurance prior to issuance or use by the insurer was fully satisfied. Active regulation of the prescription drug insurance program is further shown by the written orders issued by the Commissioner of Insurance and by the fact that the Texas Attorney General was also kept fully advised of Blue Shield's prescription drug insurance program.

B. *Regulation Of Unfair Methods Of Competition In The Business Of Insurance.*

Not only is there a scheme of general state regulation of the business of insurance involved in this action, but the Texas Insurance Code contains specific provisions applicable to the conduct alleged in Plaintiffs' Complaint. In 1951, the Texas Legislature enacted Tex.Ins.Code Ann. art. 21.21, which expressly regulates unfair competition and unfair practices in the business of insurance. The declaration of purpose of the Act states:

> "The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress [the McCarran-Ferguson Act], by defining,

> or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined." Tex.Ins.Code Ann. art. 21.21 § 1.

Article 21.21 specifically prohibits "*any* trade practice which is defined in [the] Act as, or determined pursuant to [the] Act to be, an unfair method of competition or unfair or deceptive act or practice in the business of insurance." Tex.Ins.Code Ann. art. 21.21 § 3. (Emphasis added) That statute grants specific administrative and supervisory powers to the State Board of Insurance, including the power to issue cease and desist orders. Penalties are provided for violation of such orders. Without doubt, the phrase "any" unfair method of competition encompasses the conduct challenged in this action. Furthermore, the oral deposition testimony establishes that the State Board of Insurance reviews all policy forms submitted to it with a view toward insuring compliance with Article 21.21, and that approved, as well as exempted policies, are subject to its provisions. Article 21.21 was specifically intended by its drafters to respond to the invitation of the McCarran-Ferguson Act and to withdraw from federal control the very conduct charged by Plaintiffs in this action, and to place such conduct under state control. Article 21.21 constitutes sufficient state regulation to activate the exemption provided in the McCarran-Ferguson Act. *Crawford* v. *American Title Ins. Co.*, 518 F.2d 217 (5th Cir. 1975); *Dexter* v. *Equitable Life Assurance Soc'y of the U. S.*, 527 F.2d 233 (2nd Cir. 1975).

C. *The Texas Antitrust Laws.*

In addition to the comprehensive regulation of Blue Shield's activities provided by the Texas Insurance Code,

anticompetitive practices in the business of insurance are also regulated by the Texas antitrust laws. The Texas antitrust laws declare categorically that "[e]very monopoly, trust, and conspiracy in restraint of trade . . . is illegal and prohibited." Tex.Bus. & Comm. Code Ann. § 15.04(a). Further, the Texas antitrust laws specifically prohibit conspiracies of the type alleged in Plaintiff's Complaint. Tex.Bus. & Comm.Code Ann. § 15.02. It should be noted that Plaintiffs have included in their Complaint a pendent claim under the Texas antitrust laws based upon the same facts that Plaintiffs allege give rise to a violation of the federal antitrust laws.

The existence of a state antitrust law proscribing the conduct complained of constitutes "regulation" within the meaning of the McCarran-Ferguson Act sufficient to displace the federal antitrust laws. *Meicler* v. *Aetna Cas. and Sur. Co.*, 506 F.2d 732 (5th Cir. 1975); *Sanborn* v. *Palm*, 336 F.Supp. 222 (S.D.Tex.1971); *Transnational Ins. Co.* v. *Rosenlund*, 261 F.Supp. 12 (D.Ore.1966); *California League of Ind. Ins. Producers* v. *Aetna Cas. & Sur. Co.*, 175 F.Supp. 857 (N.D.Cal.1959).

Therefore, in addition to active regulation under the Texas Insurance Code, the existence of state antitrust statutes forbidding the conduct alleged by Plaintiffs constitutes state regulation of the business of insurance sufficient to bar application of the federal antitrust laws.

IV.

THE BOYCOTT EXCEPTION TO THE MCCARRAN-FERGUSON ACT IS INAPPLICABLE

As in *Meicler* v. *Aetna Cas. and Sur. Co.*, *supra*, Plaintiffs attempt to avoid the effect of the McCarran-Ferguson exemption by relying on the Section 1013(b) boycott exception. Plaintiffs' reliance on this exception is mis-

placed. The courts have narrowly construed Section 1013 (b), which provides:

> "Nothing contained in this chapter shall render said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion or intimidation." 15 U.S.C. § 1013(b).

The sole purpose of this exception is to protect against the issuance of black-lists naming insurance companies or agents, rather than the conduct alleged by Plaintiffs in this action.

In *Meicler*, the Court stated:

> "As the district court noted, the legislative history indicates that the boycott exception was designed to reach insurance company 'black-lists' rather than refusal to sell to a particular segment of the public at other than a specified price. (Citations omitted) Appellants' broad construction of Section 1013(b) would emasculate the antitrust exemption contained in Section 1012(b) of the McCarran-Ferguson Act. We affirm the district court's holding that the boycott exception does not apply." 506 F.2d at 734.

This case does not involve black-listing and the boycott exception is inapplicable. *Addrisi* v. *Equitable Life Ins. Assurance Soc'y of the U. S.*, 503 F.2d 725 (9th Cir. 1974); *Proctor* v. *State Farm Mut. Auto Ins. Co.*, 406 F. Supp. 27 (D.D.C.1975); *Mitgang* v. *Western Title Ins. Co.*, Trade Reg.Rep. (1974-2 trade cases) ¶ 75,322 at 98,024 (N.D.Cal. October 16, 1974); *Transnational Ins. Co.* v. *Rosenlund*, 261 F.Supp. 12 (D.Ore.1966).

V.

Application of the McCarran-Ferguson Act to the Non-Insurance Company Defendants

Plaintiffs contend that Walgreen, Sommers and Rieger are not entitled to the protection afforded by the McCarran-Ferguson Act because they are not insurance companies. The exemption provided in the Act is not strictly limited to insurance companies. As shown herein, it is the "business of insurance" with which the Act is concerned.

Recent cases have allowed the exemption even though the challenged activities involved parties other than insurance companies. In *Travelers Ins. Co.* v. *Blue Cross of West. Pennsylvania*, 481 F.2d 80 (1973), the Court applied the exemption to contracts between the insurance company and hospitals. In *Schwartz* v. *Commonwealth Land Title Ins. Co.*, 374 F. Supp. 564 (E.D.Pa.1974), the exemption was applied to a fee charged to sellers of real estate by title insurance companies and agents.

It is clear that it is the nature of the conduct involved which must be looked at in order to determine whether or not the exemption should be applied. In the instant case, Walgreen, Sommers and Rieger, by having contractually agreed with Blue Shield to provide the benefits set out in the Policy, have become an integral part of the overall scheme of insurance coverage which is regulated by state law. Such integration of the providers of benefits under the Policies into the overall scheme places their actions under the Pharmacy Agreements within the "business of insurance", and they are therefore entitled to the protection afforded by the McCarran-Ferguson Act for it is clear that one cannot be brought within the web of potential liability under the Federal Antitrust laws for

participation in the complained of activity if such activity is, as in the instant case, exempt by operation of the McCarran-Ferguson Act.

VI.

Plaintiffs' Pendent Claims

As shown above, the complained of activities are exempt from the Federal Antitrust laws because of the McCarran-Ferguson Act. It is clear from the pleadings on file that jurisdiction over this action does not exist by reason of diversity of citizenship. If the Federal claims are dismissed prior to trial, it is within the ambit of this Court's discretion to decline to continue to exercise jurisdiction over the pendent state claims. No unusual circumstances are present in this case which would require the Court to retain jurisdiction over the pendent claims. *United Mine Workers of America* v. *Gibbs*, 383 U.S. 715, 86 S.Ct. 1130, 16 L.Ed.2d 218 (1966); *Lazier* v. *Weitzenfeld*, 505 F.2d 896 (5th Cir. 1975); *Kavit* v. *A. L. Stamm & Co.*, 491 F.2d 1176 (2nd Cir. 1974).

VII.

Conclusion

For the reasons set forth above, this Court concludes that the complained of activities constitute the "business of insurance". This Court further concludes that the State of Texas has regulated and is actively and effectively regulating such business of insurance within the meaning of the McCarran-Ferguson Act, and the Federal Antitrust laws are thereby rendered inapplicable. Accordingly, Defendants' motions will be granted. As shown herein, this Court has considered matters outside the

pleadings in arriving at its decision. In doing so, the essentials necessary to support the exemption have been found to exist. Therefore, it is appropriate that Defendants' motions shall be treated as Motions for Summary Judgment and disposed of as provided in Rule 56, Federal Rules of Civil Procedure. The foregoing Memorandum Opinion constitutes the Court's Findings of Fact and Conclusions of Law.

An Order consistent with the foregoing will be entered.

FINAL ORDER AND JUDGMENT OF UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF TEXAS, MAY 18, 1976

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

Civil Action No. SA-75-CA-131

ROYAL DRUG COMPANY, INC., ET AL.

v.

GROUP LIFE AND HEALTH INSURANCE COMPANY, ET AL.

ORDER

On the 18th day of May, 1976, this Court filed its Memorandum Opinion which included its Findings of Fact and Conclusions of Law in connection with the above-captioned action. Consistent with such Memorandum Opinion and the Findings of Fact and Conclusions of Law contained therein, it is hereby ORDERED, ADJUDGED and DECREED that judgment is rendered for and in behalf of Defendants Group Life and Health Insurance Company, also known as Blue Shield of Texas, Walgreen Texas Co., The Sommers Drug Stores Company and Rieger/Medi-Save Pharmacies, Inc., with respect to Plaintiffs' claims under the federal antitrust laws.

It is further ORDERED, ADJUDGED and DECREED that Plaintiffs' claims alleged to arise under the Texas antitrust laws be, and they are hereby dismissed without prejudice.

It is further ORDERED that all costs of this suit are taxed against Plaintiffs.

SIGNED and ENTERED this 18th day of May, 1976.

/s/ John H. Wood, Jr.
JOHN H. WOOD, JR.
United States District Judge

OPINION OF UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT, AUGUST 8, 1977

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 76-2746

ROYAL DRUG COMPANY, INC., d/b/a Royal Pharmacy of Castle Hills and Disco Prescription Pharmacy, et al.,
Plaintiffs-Appellants,

v.

GROUP LIFE AND HEALTH INS. CO., a/k/a Blue Shield and/or Blue Cross-Blue Shield of Texas, et al.,
Defendants-Appellees.

Aug. 8, 1977

Rehearing and Rehearing En Banc

Denied Oct. 27, 1977

* * * *

Joel H. Pullen, Stephen F. Lazor, San Antonio, Tex., for plaintiffs-appellants.

Keith E. Kaiser, R. Laurence Macon, J. Burleson Smith, San Antonio, Tex., for Group Life & Health.

William C. Church, Jr., San Antonio, Tex., for Walgreen Texas Co.

Richard B. Moore, San Antonio, Tex., for Sommers Drug Stores Co.

Charles R. Shaddox, San Antonio, Tex., for Rieger-Medi-Save Pharmacies, Inc.

Appeal from the United States District Court for the Western District of Texas.

Before GOLDBERG and HILL, Circuit Judges, and KERR,* District Judge.

JAMES C. HILL, Circuit Judge:

The plaintiffs in this civil antitrust action are eighteen independent pharmacy owners doing business in San Antonio, Texas.[1] Blue Shield is a Texas insurance company authorized by the State Board of Insurance of Texas to sell life, health and accident insurance. Three other defendants, Walgreen Texas Company, The Sommers Drug Stores Company and Rieger Medi-Save Pharmacies, Inc., also operate pharmacies in San Antonio, Texas.

The plaintiffs contend that the defendants have violated Section 1 of the Sherman Act, 15 U.S.C. § 1, by agreeing, combining and conspiring to fix the retail price of drugs and pharmaceuticals, and that the activities of the defendants have caused Blue Shield's insureds not to deal with certain of the plaintiffs, thereby constituting an unlawful group boycott. Plaintiffs also allege violations of Texas antitrust law over which the district court took pendent jurisdiction. The defendants affirmatively alleged in their answers that pursuant to the provisions of the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.*, ("McCarran Act") the complaint failed to state a claim upon which relief could be granted and that the district court lacked subject matter jurisdiction. On the basis of the McCarran Act, each defendant moved to dismiss the complaint pursuant to Rule 12(b), F.R.Civ.P. The defendants also moved that the court treat their motions as motions for

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* Senior District Judge for the District of Wyoming, sitting by designation.

[1] Since the parties have been referred to in the briefs as plaintiffs and defendants, as they were in the district court, they will be so designated in this opinion. The defendant Group Life & Health Insurance Company will be referred to herein as Blue Shield.

summary judgment pursuant to Rule 56, F.R.Civ.P. Defendants further moved the court to dismiss the claims based upon state law if the court found there was not a proper cause of action based upon federal law. The district court held that: (1) the conduct complained of by the plaintiffs constitutes the business of insurance; (2) the State of Texas has regulated and is actively regulating such business of insurance within the meaning of the McCarran Act; (3) that the boycott exception to the McCarran Act is inapplicable to the instant case; and (4) that the federal antitrust laws are, therefore, rendered inapplicable. We reverse.

I. *The Facts.*

Plaintiffs are challenging a plan of operation under which Blue Shield issues certain prescription drug insurance policies which entitled Blue Shield's insureds to purchase drugs from any pharmacy. If the pharmacy selected by the policyholder has entered into a written contract ("Pharmacy Agreement") with Blue Shield, the insured is required to pay only two dollars ($2.00), the amount of the drug deductible set forth in the policy. On the other hand, if the insured has his prescription filled by a pharmacy other than a Participating Pharmacy, he is required to pay the full price charged by the pharmacy as well as the $2.00 deductible, and then to apply to Blue Shield for reimbursement. Blue Shield will then reimburse the insured only for 75 percent of the usual and customary charge for the drug, less the $2.00 deductible.[2]

In 1969, Blue Shield sought approval from the Texas State Board of Insurance to begin issuing prescription drug insurance coverage. The Commissioner, however, dis-

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[2] The usual and customary charge is established by Blue Shield and is determined by reference to its compilation of such charges.

approved the issuance or use of such a policy. The policy remained under the consideration of the Commissioner and in September, 1969, the Commissioner issued an order exempting the policy from the approval requirements of Texas law. The defendants contend that there is uncontradicted evidence showing that an exemption order exempts the policy from nothing more than the requirement of approval by the State Board of Insurance, and that exempted policies, as well as approved policies, are subject to all statutory requirements of the Texas Insurance Code and the continuing regulation, control and supervision of the State Board of Insurance.

When the Commissioner issued his orders concerning the plan, disapproving it in the first instance, and then exempting the plan, he advised the Texas Attorney General in writing of his actions on each occasion. After receiving the exemption order, Blue Shield made a statewide mailing to licensed pharmacies offering them the privilege of entering into the Pharmacy Agreement. As a result, Blue Shield has issued the policy to various groups and has entered into the Pharmacy Agreement with pharmacies throughout the State of Texas.

In 1974, Blue Shield entered into a health care agreement, which included a prescription drug insurance, to provide insurance benefits to groups in Bexar County, Texas. In order to implement this agreement, in September, 1974, a policy form virtually identical to the one submitted in 1969 was filed with the State Board of Insurance for approval prior to its issuance or use. This policy was approved in October, 1974. Subsequently, Blue Shield has issued the policy to various groups in Bexar County and has offered to virtually all licensed pharmacies in San Antonio the opportunity of entering into the Pharmacy Agreement. Nine of the plaintiffs in this case accepted Blue Shield's offer and now operate Participating Pharmacies. In recent years, the number of pharmaceutical sales covered by this policy have risen dramatically. For example, between early 1972 and October, 1975, there was a 3,100 percent increase in the number of pharmaceutical claims processed by Blue Shield under the policy. In October, 1975, Blue Shield was handling these claims at the rate of approximately 31,000 claims per month as compared with only 1,000 claims per month in early 1972.

For each sale made under the plan, a Participating Pharmacy is limited to a $2.00 markup, which is known as a "professional dispensing fee," irrespective of its actual acquision cost for a particular drug. The plaintiffs note that, with respect to highly expensive drugs, the Pharmacy Agreement can result in a markup of no more than two percent, which will not even cover the interest on its investment inventory.

II. *Summary of Contentions of Appeal.*

The plaintiffs argue that the retail sales price, as fixed in the Pharmacy Agreement between Blue Shield and the defendant pharmacy chains, has been set at a level below that at which small independent pharmacies can profitably conduct business. They claim that only large, high volume chains that sell many items in addition to drugs can afford to operate pursuant to the Pharmacy Agreement. They also contend that the Agreement fixes the retail price of drugs at a level which eliminates the only effective means by which small independent pharmacies can compete with the large chains—the provision of services. They argue that, since signatories of the Pharmacy Agreement are limited to the same retail sales price whether they provide home deliveries, twenty-four hour service, or no service at all, the ability of the independents to compete is effectively destroyed. The plaintiffs contend that Blue Shield's plan of operation not only

encompasses the fixing of prices in the defendant pharmacy chains, but it extends to the pharmaceutical industry as a whole. They contend that small independent pharmacies are given the choice of either signing the price fixing agreement or being forced out of business.

The plaintiffs also argue that there are two types of coercion of Blue Shield's subscribers inherent in the plan. First, the subscriber receives markedly reduced benefits if he patronizes a pharmacy that refuses to sign the price-fixing agreement. Although he would pay only the $2.00 drug deductible for each prescription filled by a participating pharmacy, he would ultimately pay an amount representing 25 percent of a reasonable charge for the drug, in addition to the $2.00 drug deductible, for each prescription filled by a nonsigning pharmacy. The plaintiffs also point out that the differential in benefits between participating and nonparticipating pharmacies is intended to coerce Blue Shield's policy holders not to patronize nonsigning pharmacies *in Texas* and thereby to coerce such pharmacies to sign the price-fixing agreement. This allegation is based on the policy itself, which provides that the subscriber will be reimbursed 100 per cent of a reasonable charge for the drug, less the $2.00 drug deductible, when he patronizes a nonsigning pharmacy outside the State of Texas.

The plaintiffs also contend that there is a second and more subtle step to the coercion. If a pharmacy signs the Pharmacy Agreement and agrees to charge only the stipulated amount for drugs sold to Blue Shield Subscribers, it will be reimbursed directly by Blue Shield in the amount of the acquisition cost, and the subscriber will be obligated to pay the pharmacy at the time of purchase only the $2.00 drug deductible. If the pharmacy has refused to sign the Agreement, however, Blue Shield will not deal with the pharmacy directly, and the subscriber

must pay the entire retail sales price at the time of purchase, in addition to the $2.00 fee. After paying the entire sales price at the time of purchase, he must file a claim with Blue Shield seeking reimbursement. Thus, an insured has the additional burden of filing a claim for reimbursement, and he must accept reduced benefits in order to patronize the drug store of his choice.

Having made the above claims, the plaintiffs are immediately confronted with defendant's argument that its activities are exempt from the antitrust laws by virtue of the McCarran Act. The McCarran-Ferguson Act provides that the Sherman Act, the Clayton Act and the Federal Trade Commission Act shall be applicable to the business of insurance only "to the extent that such business is not regulated by state law."

Disputing the applicablility of the McCarran Act exemption, the plaintiffs contend that a three-step analysis is necessary to determine whether an insurance company's challenged activities fall within the Act's exemption. First, they contend, the court must determine whether the challenged activities constitute the "business of insurance." Second, it must determine whether the activities in question are regulated by state law. Third, the court must determine the presence or absence of boycott, coercion, or intimidation.[3] The latter requirement derives from Section 3(b) of the McCarran Act, which states as follows: "Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate or act of boy-

[3] A negative finding for the first question obviates the necessity for a determination with respect to the second and third steps, and precludes application of the McCarran Act. *SEC* v. *Nat'l Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564, 21 L.Ed.2d 668 (1969); *American General Insurance Co.* v. *FTC*, 359 F.Supp. 887 (S.D. Tex. 1973), *aff'd.*, 496 F.2d 197 (5th Cir. 1974).

cott, coercion or intimidation." 15 U.S.C. § 1013(b) (1970).

III. *Do the Defendants' Activities Constitute the Business of Insurance?*

The stepping off point of our analysis is the general principle that statutory exceptions to the antitrust laws "are to be strictly construed." *Abbott Labs* v. *Portland Retail Druggists Ass'n, Inc.*, 425 U.S. 1, 96 S.Ct. 1305, 47 L.Ed.2d 537 (1976); *FMC* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 93 S.Ct. 1773, 36 L.Ed.2d 620 (1973). The notion that "our cases have repeatedly established . . . a *heavy presumption against* implicit [antitrust] exemptions" was recently reaffirmed in *Abbott Labs, supra.*[4] Moreover, it is clear that merely because challenged conduct has been engaged in by an insurance company does not dictate its characterization as the "business of insurance" under the McCarran Act. *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564, 21 L.Ed.2d 668 (1969). The question presented under the McCarran Act, therefore, "is whether the activities complained of, *even though they may be actions taken by an insurance company*, are part of the 'business of insurance' which Congress sought to remove from federal regulation." *Fry* v. *John Hancock Mutual Life Ins. Co.*, 355 F.Supp. 1151, 1153 (N.D.Tex.1973) (emphasis added).

In *National Securities* the Supreme Court held that the "business of insurance" included (1) "the relationship between insurer and insured," (2) "the type of policy which could be issued, its reliability, interpretation and enforcement;" (3) "other activities which relate . . . to

[4] Relying on this general principle, plaintiffs argue that if the challenged activities do not clearly constitute the business of insurance, they fall outside the McCarran Act's protective umbrella and are subject to the full force and effect of the antitrust laws.

their status as reliable insurers." Relying on the first of these definitions, the plaintiffs note that the McCarran Act's focus is on the relationship between the insurer and the insured. The plaintiffs argue that a crucial determination is the question how closely the challenged activity concerns the relationship between the insurance company and the policyholder. The activities challenged herein, according to the plaintiffs, relate primarily to relationships other than that between the insurer and its policyholders and therefore are not peculiar to the insurance industry. The plaintiffs concede that there may be effects on policyholders resulting from the Pharmacy Agreement, but they minimize these as peripheral and secondary to the effects on the relationship between competing pharmacies and between such pharmacies and their customers.

The defendants contend, and the district court found, that the plan of operation followed by Blue Shield, including the Pharmacy Agreement, relates directly to its status as a reliable insurer. We cannot agree. It is beyond peradventure that every action taken by an insurance company to enhance its status as a "reliable insurer" does not necessarily constitute the "business of insurance" within the meaning of the McCarran Act. Moreover, an agreement which does not otherwise constitute the business of insurance is not automatically embraced within the protection of the McCarran Act simply because it benefits policyholders either directly, or indirectly by strengthening the financial condition of the insurer.

Defendants allege that the contractual arrangements between Blue Shield and Participating Pharmacies require nothing more than the performance of obligations owed to Blue Shield's insureds under the drug insurance policies. In concluding that "[t]he Pharmacy Agreement directly pertains to the relationship between Blue Shield and its insureds" the district court held that the Phar-

macy Agreement "is simply the performance of the insurer's obligations owed to its insureds under the insurance contract and nothing more." Despite these characterizations of the contractual arrangement, we find that the agreeements between Blue Shield and Participating Pharmacies do not require Blue Shield to fix prices or to produce other anticompetitive effects in the pharmaceutical industry. Blue Shield's sole obligation is to see that the insured receives prescription drugs and "shall be required to pay no more than the drug deductible for each of such covered drugs." It is unnecessary for Blue Shield to agree with pharmacies to fix retail sales prices in the pharmaceutical industry. Blue Shield's policyholders are basically unconcerned with the contract between the insurer and the Participating Pharmacy. They are obligated to pay a Participating Pharmacy two dollars ($2.00) for a prescription regardless of the presence or absence of a price fixing arrangement. Thus, by minimizing costs and maximizing profits, the Participating Pharmacy Agreements inure principally to the benefit of Blue Shield.

The plaintiffs attempt to illustrate by example that the relationship primarily affected by the Pharmacy Agreement and the alleged coercion is that between competing pharmacies and not the relationship between insurer and insured. If the challenged activities in this case are held to constitute the business of insurance, they contend, then automobile insurers will be able to utilize Participating Repair Shop Agreements and coercion to fix prices for parts and labor in the automobile industry. Similarly, they contend that fire insurance companies would be able to execute Participating Construction Company Agreements and thereby combine and conspire with large construction companies to set prices for the repair and rebuilding of homes or buildings damaged by fire. The plaintiffs contend that Congress never intended that the

McCarran Act be utilized to shield such activities from application of the federal antitrust laws. They note that Congress, in enacting the McCarran Act, may have condoned state supervised rate setting, but Congress was opposed to private price fixing and did not intend that such activity be shielded from federal scrutiny.

The defendants argue that the Pharmacy Agreement is so inextricably intertwined with the policies that it would be impossible for Blue Shield to fulfill its contractual obligations to its insureds in the absence of such agreements with the pharmacies. The defendants also dispute plaintiffs' arguments that if Blue Shield's activities are permitted, automobile insurers will utilize Participating Repair Shops and fire insurance carriers will enter into Participating Construction Company Agreements. The defendants contend that the types of insurance referred to by the plaintiffs are not at issue here and such types of insurance are regulated by the provisions of the Texas Insurance Code which are not similar to the ones involved in this case. They also contend that Blue Shield was statutorily required to submit the policies to the state board prior to issuance or use and that the Commissioner authorized the use of the policy and Pharmacy Agreement. Finally, they contend that the activities suggested in the hypothetical examples would require careful examination of the existing laws and regulatory devices relating to automobile insurance and fire insurance. In short, they contend that these hypotheticals are nothing more than speculation and conjecture.

We conclude that Blue Shield is no more obligated to fix the retail prices of pharmaceuticals than an automobile insurer is obligated to its insureds having deductible policies to fix the prices charged for parts and labor. Just as the automobile insurer is obligated to pay the cost of repair, whatever it might be, over and above the appli-

cable policy deductible, Blue Shield is obligated to pay the cost of prescription drugs over and above the two dollar ($2.00) drug deductible. Even though an automobile insurer might be able to guarantee by contract that repairs are done for its customers on a "cost" basis, thereby achieving increased profits or reduced rates, such agreements do not thereby become immune from antitrust scrutiny. *Contra, Proctor* v. *State Farm Mutual Insurance Co.*, 406 F.Supp. 27 (D.D.C.1975).

The plaintiffs next contend that the Pharmacy Agreement produces results far beyond the simple performance of Blue Shield's responsibilities owed to its insureds under The Prescription Drug Insurance Policy. Blue Shield itself may have recognized that the Pharmacy Agreement goes beyond its obligations under the prescription plan. The plaintiffs introduced into evidence a letter between two Blue Shield executives which indicated a concern over antitrust problems and suggested that the company camouflage the price fixing arrangement as a "mass accounting agreement." The evidence introduced in the trial court stated as follows: "I think it would be best to draft the contract so that the Insurance Board would require filing of the mass accounting agreement [Pharmacy Agreement] to strengthen your base on anti-trust. Drafting problems will get sticky here, but let's pass on that for now." The plaintiffs contend that this letter carries the Blue Shield plan far beyond the protection of the McCarran Act. They contend that Congress did not contemplate or intend that the McCarran Act should shield from antitrust scrutiny any insurance company's efforts to control the magnitude of its policyholder's claims through the elimination of price and other forms of competition in the industries providing goods and services covered by the insurance policy. Since these activities are not regulated by the State, they contend that the McCarran Act exemption does not apply.

We find that the Pharmacy Agreement goes beyond Blue Shield's obligation as an insurer and places the firm in the business of providing products and services. Blue Shield has agreed to provide protection against the risk that a policyholder will require pharmaceuticals. In order to meet that obligation, Blue Shield is not required to guarantee the provision of services on a "cost-plus" basis or any other basis which might be more economical than the retail purchase of such products. That Blue Shield may wish to protect itself and its customers from rising costs in the pharmaceutical industry does not transform the Pharmacy Agreement into the business of insurance. In fact, the best way for the firm to protect itself from rising costs is to establish and periodically adjust its rate structure to reflect the impact of inflation. Such measures, which are by no means foreign to the insurance business, involve far less intrusion into the pharmaceutical industry and, consequently, avert the potentially anticompetitive effects alleged here.

The plaintiffs next attempt to come to grips with *Travelers Insurance Company* v. *Blue Cross*, 481 E.2d 80 (3rd Cir.), *cert. denied*, 414 U.S. 1093, 94 S.Ct. 724, 38 L.Ed. 2d 550 (1973), by arguing that the McCarran Act does not apply *ipso facto* to every direct contractual relationship between an insurance company and a provider of benefits. In *Travelers*, the Third Circuit held that the contractual arrangements consummated between Blue Cross and various hospitals for the furnishing of services under insurance policies constituted the business of insurance and, thus, the relationship fell within the McCarran Act exemption. There, as here, the relationship was a direct contractual relationship the result of which was the performance of obligations owed to the insured by the insurer on an economically favorable basis. The plaintiffs have attempted to distinguish *Travelers* by

arguing that the Third Circuit was merely approving the actions of the Insurance Commissioner of Pennsylvania who was exerting pressure on the large insurance companies to exercise their power over hospitals to reduce hospital costs. This interpretation, with which we agree was adopted in *Doctors, Inc.* v. *Blue Cross*, 431 F.Supp. 5 (E.D.Pa. 1975), *aff'd per curiam*, 557 F.2d 1001 (3d Cir. 1976).[5] Moreover, the *Travelers* decision was based in large measure on the Pennsylvania legislature's control over rates charged by nonprofit hospitals. That regulation was undertaken pursuant to a statutorily created interrelationship between the rates charged by nonprofit health insurers and nonprofit hospitals, which interrelationship was to be regulated by the Pennsylvania Insurance Department. The plaintiffs note that the Texas Legislature has not chosen indirectly or directly to control the rates charged by pharmacies either by directing and controlling contracts between insurers and pharmacies or by creating an interrelationship between the rates charged by pharmacies and those charged by insurers. Since *Travelers* held simply that the contract between a nonprofit health insurer and a nonprofit hospital was shielded by the McCarran Act from attack, *Travelers* carries little precedential value in this appeal.

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[5] The court indicated the narrow scope of *Travelers* as follows:

> It is therefore readily apparent from the reading of the *Travelers* case that the Third Circuit is approving the *actions of the Insurance Commissioner of Pennsylvania when he exerts pressure* on the large insurance companies to get them to exercise their power over hospitals to force the hospitals to cut costs wherever possible. This is exactly what Blue Cross was doing in our case at the bequest of the Insurance Commissioner. Therefore, since the McCarran-Ferguson exemption was applicable in Travelers . . ., I hold today that the McCarran-Ferguson exemption is applicable in *Doctors, Inc.* . . . *Doctors, Inc. vs. Blue Cross*, 431 F.Supp. 5, 10 (E.D.Pa. 1975), *aff'd* 557 F.2d 1001 (3d Cir. 1976) (emphasis added).

Rather, the instant case is more nearly akin to *Battle* v. *Liberty Nat'l Life Ins. Co.*, 493 F.2d 39 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110, 95 S.Ct. 784, 42 L. Ed.2d 807 (1975). In *Battle* several funeral homes and directors brought suit against an insurer, which issued burial policies, and the insurer's wholly owned subsidiary which supplied merchandise and services required by the insurer's policies. Although this court found coercion with respect to the insurer's discrimination in benefits, the court felt that the facts were inadequately developed to make a conclusive determination on the McCarran Act issue. Nonetheless, the court stated as follows: "[I]t might be plausibly argued that these facts do not constitute the business of insurance as contemplated by the McCarran Act and thus do not fall within its exemption."[6] The court noted that the obligations under the insurer's arrangement might be related to the business of insurance, but the obligations were so remotely related as to be subject to the antitrust laws. Relying on *Battle*, the plaintiffs argue that the defendants' activities challenged herein are not peculiar to the insurance industry and are not the business of insurance. They argue that by providing markedly decreased benefits to those subscribers who patronize a nonparticipating pharmacy, Blue Shield intentionally and overtly coerces its subscribers to boycott these pharmacies. Not only does this

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[6] The Court stated:

> It appears that, since the insurance contract confers far more benefits upon the policyholder if he uses an authorized funeral home, the policyholder is subtly coerced into dealing only with the authorized home. The imposition of this restraint would effectively foreclose the unauthorized funeral director's access to a substantial portion of the market. 493 F.2d at 44-45.

The court held that these facts "if established, would tend to support a finding of unreasonable restraint of trade."

493 F.2d at 44.

boycott operate to coerce the nonsigning pharmacies to participate in the plan, it also forecloses nonsigning pharmacies from a significant portion of the market and secures for participating pharmacies the sales of prescription drugs required by Blue Shield's claimants. Since this activity is not peculiar to the insurance industry, plaintiffs argue that it does not constitute the business of insurance. As in *Battle*, the contractual agreements here under review are somewhat related to the business of insurance. The relationship, however, is so attenuated that it must be subject to the antitrust laws. As the plaintiffs have so well articulated, "it is not the office of the insurance industry to set the prices in the various sectors of our economy so that insurers will enjoy an added measure of control over the magnitude of individual claims."

The plaintiffs next take issue with the finding of the district court that a 1962 Opinion of the Texas Attorney General has concluded that the challenged activity constitutes the business of insurance. The court read the 1962 Opinion as a determination by the Texas Attorney General that a plan "substantially similar" to Blue Shield's plan constituted the business of insurance. Plaintiffs contend that the Attorney General's Opinion held only that the particular firm in question was an insurance company and not that a program substantially similar to Blue Shield's constituted the business of insurance. The plaintiffs allege that the Attorney General's Opinion was based strictly on the facts presented and that it bears no logical relevance to the question whether the activities challenged in this suit constitute the business of insurance. Although the 1962 opinion is not without ambiguity, it appears to focus on the status of the company itself; it does not conclusively establish whether the State considers a plan such as Blue Shield's Pharmacy Agreement to constitute

"the business of insurance." Thus, we are compelled to eschew the heavy weight usually given a state's determination that an activity constitutes the "business of insurance" in favor of the interpretation given the term by the federal courts. *See SEC* v. *Variable Annuity Co.*, 359 U.S. 65, 69, 79 S.Ct. 618, 3 L.Ed.2d 640 (1959).

The State has shed very little light on this matter since the 1962 Attorney General's Opinion discussed above. Although the plaintiffs argue that the State Board of Insurance does not consider The Pharmacy Agreement to encompass or constitute the business of insurance, it is by no means clear that the State has even considered the question. The district court concluded that "[t]he State of Texas has actively regulated the activities challenged in plaintiff's complaint since the inception of Blue Shield's Prescription Drug Insurance *Program.*" (emphasis added). Plaintiffs contend that the State uses the word "program" loosely in that the Board of Insurance approved nothing more than the insurance policy itself and it did not consider the Pharmacy Agreement, which is at issue in this case.

It is clear from the record that the Board has never approved the Pharmacy Agreement, and the Division Manager of the Board's Policy Approval Division, a Mr. Pogue, testified that he thought the Pharmacy Agreement was outside of the State's regulatory control. He stated as follows: "I do not feel that a contract of that nature falls within the jurisdiction of the State Board of Insurance." Plaintiffs argue that the Pharmacy Agreement does not fall within the jurisdiction of the State Board of Insurance simply because it does not constitute the business of insurance.

There is some testimony which contradicts the testimony of Mr. Pogue. A former employee of the State

Board of Insurance, a Mr. Connor, gave an arguably contradictory response to what the plaintiffs describe as a "convoluted question" concerning the exemption of Blue Shield's Prescription Drug Insurance Policy form. With respect to this exemption, the following exchange took place between counsel for Blue Shield and Mr. Connor:

> Q. [By Mr. Kaiser] . . . Mr. Connor, at the time of the issuance of this Exemption Order that you are looking at right now, was it your opinion that this particular contract which is marked Deposition Exhibit 52 [the Prescription Drug Insurance Policy], along with the Participating Drug Pharmacy Agreement which Blue Shield proposed to issue, was it your opinion *that that* constituted the business of insurance?
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> A. [Mr. Connor] Yes.

Plaintiff concedes that one might draw from this exchange that Connor thought the Pharmacy Agreement was a part of the business of insurance. Plaintiffs argue, however, that the phrase "that that" leaves the issue in doubt because Connor may have understood the phrase "that that" to refer only to the policy itself and not to the Pharmacy Agreement. This position is bolstered by Connor's earlier testimony, wherein he stated that he did not recall having occasion to review the Pharmacy Agreement before drafting the Exemption Order and that he had "no recollection of receiving the document."

The testimony of these officials, therefore, at best raises a factual issue concerning the State's position. It, like the 1962 Attorney General's Opinion, is not a definitive statement of the State's position.

The defendants nonetheless place great emphasis on the extent of state regulation and attempt to minimize plaintiffs' arguments concerning the "business of insurance." They rely on *Crawford* v. *American Title Ins. Co.*, 518 F.2d 217 (5th Cir. 1975), where this court held that pervasive regulation by the State of Alabama over antitrust matters in the insurance industry precluded application of the federal antitrust laws. The problem with the defendants' position is that the McCarran Act applies only when the activity concerned is the business of insurance *and* the activity is regulated by the State. In *Crawford* there was no question that the challenged conduct constituted the business of insurance; rather, the issue was the extent and pervasiveness of state regulation. There seems to be no question that the State of Texas regulates the insurance industry quite vigorously, but there is no similar indication that the activities complained of are considered the business of insurance by the State or by any common sense interpretation of that term.[7]

We recognize that several district courts have rendered decisions contrary to the conclusion we reach today. *Manasen* v. *California Dental Services*, 424 F.Supp. 657 (N.D. Cal. 1976); *Proctor* v. *State Farm Mutual Insurance Co.*, 406 F.Supp. 27 (D.D.C. 1975); *Schwartz* v. *Commonwealth Land Title Insurance Co.*, 374 F.Supp. 564 (E.D. Pa. 1974), subsequent proceedings reported at 384 F. Supp. 302 (E.D.Pa. 1974); *Nankin Hospital* v. *Michigan Hospital Service*, 361 F.Supp. 1199 (E.D.Mich. 1973); *California League of Independent Insurance Producers* v. *Aetna Casualty & Surety Co.*, 175 F.Supp. 857 (N.D.Cal. 1969). Indeed, two such cases have been affirmed on appeal. *Anderson* v. *Medical Service of the District of Co-*

[7] The McCarran Act likewise affords no antitrust exemption to the so-called noninsurance company defendants who are parties to this litigation. Indeed, it would be highly anomalous for this court to conclude that the sale of pharmaceuticals by these defendants constitutes the "business of insurance" for purposes of federal antitrust law.

lumbia, 551 F.2d 304 (4th Cir. 1977); *Frankford Hospital* v. *Blue Cross*, 554 F.2d 1253 (3d Cir. May 2, 1977). Perhaps the most far-reaching of these is the *Manasen* case, in which the district court concluded that the McCarran Act exemption applied to a nonprofit corporation engaged in the administration and operation of prepaid dental care programs. The defendant corporation administered prepaid dental care plans under agreements and contracts with various subscriber groups and subscribing purchasers, including governmental bodies, employer organizations, and joint employer-labor trust funds. The subscribers paid periodic premiums to CDS in exchange for future dental services performed for individuals on whose behalf the premiums were paid.

Professional services were performed by practicing dentists who were classified by CDS as "participating" or "nonparticipating" dentists. In order to attain the "participating" status, a dentist was required to look solely to CDS for payment and to set patients' fees at levels not in excess of the amounts established in a CDS approved fee schedule. Any dentist who did not agree to limit his fees to the range specified by CDS would be classified by the corporation as "nonparticipating." Covered patients who selected participating dentists to perform services would receive full benefits under the program. Patients seeking care from nonparticipating dentists, however, would receive less than the full benefits from CDS. The plaintiffs alleged that this arrangement had the effect of excluding nonparticipating dentists from the CDS market since a CDS patient who sought services from a nonparticipating dentist suffered a financial detriment. Although the defendant corporation was not an insurance company, the court concluded that it was engaged in the business of insurance for McCarran Act purposes. The court placed considerable weight on the favorable impact of the arrangement on the company's insurance rates:

> It is undisputed that the level of dentists' fees are a major factor in determining policy premiums. CDS' payment arrangements to service providers are critical elements in CDS' contractual agreements with its subscribers. These arrangements are intimately related to the interpretation and implementation of CDS' policies and to its reliability as an insurer. Accordingly, the Court finds that the activities challenged in the instant complaint constitute part of the "business of insurance" within the meaning of the McCarran Act.
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> 424 F.Supp. at 666-67 (footnote omitted).

We find ourselves in serious disagreement with the rationale underlying the *Manasen* decision. An activity is not a part of the business of insurance solely because it has an impact, favorable or otherwise, upon premiums charged by the insurer. Monopolistic or coercive activities in "provider industries" may often have a favorable economic impact upon the rates or the costs of insurance companies. But such practices do not become clothed with McCarran Act protection simply because an insurance company has contracted to pay the provider for products or services.

In *SEC* v. *Nat'l Securities Inc.*, *supra*, the Supreme Court held that the activity of two insurance companies in merging did not constitute the business of insurance, despite the fact that the transaction undoubtedly affected policyholders in terms of the security of their insurance contracts and the reliability of their insurers. Moreover, business activities of insurance companies not peculiar to the insurance industry are outside the scope of the McCarran Act. *Center Ins. Agency* v. *Byers*, (N.D.Ill. 1976); *American Family Life Assurance Co.* v. *Planned Marketing Associates*, 389 F. Supp. 1141 (E.D.Va. 1974); *American General Ins. Co.* v. *FTC*, 359 F.Supp. 887 (S.D. Tex. 1973), *aff'd* 496 F.2d 197 (5th Cir. 1974). As indicated by the activities of the noninsurance company in

Manasen, supra, the activity complained of by plaintiffs is not peculiar to the insurance industry. To be sure, price fixing and coercion induced by firms with superior bargaining power are often found in all industries. Thus, Blue Shield's attempts to control costs in the pharmaceutical industry might just as easily be undertaken by a noninsurance firm attempting to meet a contractual obligation to deliver drugs to a wholesale or retail purchaser.

Manasen and other cases have emphasized the favorable impact that price fixing and coercion have had on insurance premiums and the "reliability" of the insurers. It is conceivable that the public might benefit from price fixing arrangements as long as the parties to the arrangement agree to keep prices below free market levels. The Congress, however, has foreseen that the power to fix prices might not always be beneficially administered by those parties holding the power once their competitior has been put out of business. It is quite clear that competitors can be destroyed by those whose financial resources permit them to reduce prices until their competition is eliminated, only for the purpose of raising prices in the long run. Whether such economic coercion is proper is not for a court to decide. It is a matter of national policy which has been addressed by the Congress, from which any change will originate only after appropriate investigation, hearings and deliberation. We apply the law as presently determined by the Congress and we hold that the antitrust laws are applicable to the arrangements challenged herein.

We conclude, therefore, that Blue Shield's Pharmacy Agreement is not a part of the business of insurance and is not shielded from antitrust scrutiny even though it may have some effect upon the company's policyholders and rates.

REVERSED.

JUDGMENT OF UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT, AUGUST 8, 1977

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

[Caption Omitted in Printing]

JUDGMENT

This cause came on to be heard on the transcript of the record from the United States District Court for the Western District of Texas, and was argued by counsel;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, reversed;

It is further ordered that defendants-appellees pay to plaintiffs-appellants, the costs on appeal to be taxed by the Clerk of this Court.

August 8, 1977

Issued as Mandate:

NOTICE OF ORDER DENYING PETITION FOR REHEARING AND REHEARING EN BANC, OCTOBER 27, 1977

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

OFFICE OF THE CLERK
Tel 504—589-6514
600 Camp Street
New Orleans, La. 70130

Edward W. Wadsworth
Clerk

October 27, 1977

TO ALL PARTIES LISTED BELOW:

NO. 76-2746—ROYAL DRUG COMPANY, INC., ETC., ET AL. v. GROUP LIFE AND HEALTH INSURANCE CO., ETC., ET AL.

Dear Counsel:

This is to advise that an order has this day been entered denying the petition () for rehearing,** and no member of the panel nor Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Local Fifth Circuit Rule 12) the petition () for rehearing en banc has also been denied.

See Rule 41, Federal Rules of Appellate Procedure for issuance and stay of the mandate.

Very truly yours,

EDWARD W. WADSWORTH
Clerk

By /s/ BRENDA M. HAUCK
Deputy Clerk

** on behalf of appellees, Group Life and Health Ins. Co.

EXHIBITS

EXCERPTS FROM DEPOSITION OF JUDITH J. JOHNSON, NOVEMBER 20, 1975

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

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* * * *

[4] DIRECT EXAMINATION

BY MR. PULLEN:

Q Would you state your full name, please?
A Judith J. Johnson.
Q Where do you live, Miss Johnson?
A In Dallas.
Q What particular address?
A 7915 Rock Willow, Apartment 152.
Q Who is your present employer?
A Blue Cross-Blue Shield of Texas.
Q Now, is that a corporation?
A Yes, it is.
MR. KAISER: Now, if you are not sure—
THE WITNESS: Well, Blue Cross, Incorporated.
Q (By Mr. Pullen) What is the actual corporate name if you know?
A Group Hospital Service, Incorporated.
Q Group Hospital—
A Service, Incorporated.
Q Incorporated? All right. Miss Johnson, have you ever given a deposition before?
[5] A No, I have not.
Q All right. Well, let me tell you what goes on. I will ask you questions and this young lady will take down the questions and your answers. If for any reason you don't understand the question, well, please tell me and

Excerpts from Deposition of Judith J. Johnson

also if you will please speak up because she can't take down nods of the head.

A Okay.

Q If you for any reason want to take a break or to consult with Mr. Kaiser, well, just state so.

A Thank you.

Q Are you familiar with the company called Group Life and Health Insurance Company?

A Yes, I am.

Q That is not the company that employs you?

A Yes, it is.

Q All right. So Group Life And Health Insurance Company is your employer at this time?

A Along with Blue Cross & Blue Shield, Group Hospital Service, Group Medical And Surgical Service and Group Life and Health.

Q All right. Who do you receive your check from; which of the companies?

A Group Hospital—

MR. KAISER: What is on the check? Who is the [6] maker of the check? Do you know? If you don't know just say so.

THE WITNESS: I don't know.

Q (By Mr. Pullen) As long as it's good it's all right? All right. What is your present position?

A I'm Assistant Vice President of Medical Administration.

Q And what does that entail? What are your duties?

A Are you asking only in relation to the drug program or overall duties?

Q No, overall.

A We have two departments in the Medical Division; Reasonable Charge Department and the Utilization Review Department. My duties require that I oversee the administrative portion of these two departments which process primarily Medicare Part B claims. In additioin

Excerpts from Deposition of Judith J. Johnson

I'm responsible for the on-going administration of the Blue Shield Prescription Drug Program with pharmacies as it relates to enrolling participating pharmacies.

Q How long have you been employed by this group of companies or any of them?

A Twenty-six years.

Q When you first came with the company what [7] was your position?

A Clerk-typist.

Q How long did you stay at that position?

A Six months.

Q Then did you move up?

A Stenographer for six months. Secretary to the medical director from 1950 until 1959. Secretary to the president from 1959 until 1963. In 1963 I retired for five months and returned as secretary to the medical director. I remained in that position until July the 1st of 1972. I became administrative assistant to the vice president medical director and then in January of this year I became assistant vice president.

Q Who is your president [*sic;* "present and"] immediate superior?

A The vice president medical director.

Q What is his name?

A Dr. Louis William Conradt.

Q How long has he been with the company to your knowledge?

MR. KAISER: Just to the best of your knowledge.

THE WITNESS: Since February of 1973.

* * * *

[10] Q What was it in 1969 that led to the establishment of this program?

A The United Auto Workers National Contract.

Q Now, how did that relate to Texas?

Excerpts from Deposition of Judith J. Johnson

THE WITNESS: May I consult with my—
MR. PULLEN: Sure.

(A discussion was had off the record.)

THE WITNESS: I'm not sure of the specifics of the program.

Q (By Mr. Pullen) What was it that led to it becoming part of the Blue Cross-Blue Shield program in Texas as best you know?

A As best I know from my own knowledge and from what I have read?

Q Yes.

A It was the United Auto Workers contract and we had the United Auto Workers covered in Texas and nationally—the drug program was being offered nationally.

• • • •

[12] Q Are you aware of the conversations that Dr. Ferguson or anyone else here at Blue Cross-Blue Shield had with respect to this?

A No, I'm not.

Q Have you ever seen anything in writing regarding it?

A Not that I recall.

Q All right. Now, at that time I believe you said you were secretary to the medical director?

A That's right.

Q All right. Was your only participation at that time the normal duties of the secretary with regard to whatever your employer asked you to do as far as secretarial nature?

A Yes.

Q Now, did that ever change as far as your duties with regard to that program?

A Yes, on July 1, 1972, when I became administrative assistant.

Excerpts from Deposition of Judith J. Johnson

Q Prior to October of 1969, was there any similar type of plan offered to a subscriber by Blue Cross-Blue Shield?

A Not to my knowledge.

Q Do you know other than the United Auto Workers Plan whether the company got its source of [13] information from anyone else or any other company?

A I do not know.

Q All right. How was the plan brought to the attention of the pharmacist[s] in Texas as to whether they wanted to execute one of these agreements?

A A letter was sent to the pharmacist[s] inviting them to become a participating pharmacy.

MR. KAISER: Let's go off the record a minute.

(A discussion was had off the record.)

(The last question was read back by the Court Reporter.)

Q (By Mr. Pullen) You are familiar with the Participating Drug Pharmacy Agreement, are you not?

A Yes.

Q Has that ever changed since 1969?

A No, it has not.

Q In other words, the agreement that's being used today and which has been used since 1969 is still the identical agreement?

A Yes, sir.

MR. PULLEN: All right. Let's go off the record.

(A discussion was had off the record.)

[14] MR. KAISER: Mark all exhibits in this case sequentially in numerical order. What did we do with Hatfield?

MR. PULLEN: Other than Hatfield.

Excerpts from Deposition of Judith J. Johnson

MR. KAISER: Other than the deposition of Mr. M. A. Hatfield counsel will stipulate that we will mark all deposition exhibits from here on out sequentially beginning with Deposition Exhibit Number 1 ad infinitum. Do you want also to stipulate that we can introduce Xerox copies as opposed to the originals without any objections to the best evidence rule?

MR. PULLEN: Right.

MR. KAISER: Is that okay with you?

MR. WALRAVEN: Fine.

(Deposition Exhibit Number 1 was marked for identification and a Xerox copy will be attached to the deposition.)

Q (By Mr. Pullen) Miss Johnson, I'm going to hand you a Participating Drug Pharmacy Agreement which has been marked as Deposition Exhibit 1 and ask you if that agreement is the agreement form that has been used since the inception of the prepaid drug plan?

MR. KAISER: Counselor, are you referring to the agreement with the exception of the handwritten [15] portions filled in on the blanks?

Q (By Mr. Pullen) Yes. In other words, just the printed portion of it.

A Yes, it is.

Q All right. And this agreement has never been changed as to the printed terms to your knowledge since its inception?

A No, it has not.

Q Do you know who drafted that agreement?

A No, I do not.

* * * *

[17] Q You did not participate in these contacts?

A No, I did not.

Excerpts from Deposition of Judith J. Johnson

Q Do you know who did?

A No, I do not.

Q How did you secure the names of the pharmacist[s] who were invited to execute this agreement?

A The file reflects that in 1969 a listing was obtained from the Texas State Board of Pharmacies.

Q All right. So then this was mailed to all of the pharmacies on that list as far as you know?

A As far as I know.

Q Were there any rules or regulations as to whether a pharmacy would or would not be acceptable to execute this agreement insofar as Blue Cross-Blue Shield was concerned?

A Of course they must be a licensed pharmacy and to my knowledge that's the only requirement.

Q In other words, were there any written policies here at Blue Cross-Blue Shield concerning who could execute the agreement?

A None other than the agreement itself and the manual which contains essentially the same wording.

Q Now, what is the manual?

A Participating Drug Manual which is sent to each participating pharmacy.

* * * *

[24] Q How was the determination made to provide for payment of a fixed $2.00 fee to the pharmacist?

A I do not know.

Q Do you know if any studies were made as to whether that was an adequate fee?

A I do not know.

Q Can you tell me who might know?

A There were a number of people involved in 1969 and I'm sorry I cannot specifically give you a name.

Excerpts from Deposition of Judith J. Johnson

Q All right. Just give me the names of the people who were involved.

A Well, of course Dr. Doyle Ferguson who is now deceased; our legal division.

Q Now, who was in the legal division then?

A Mr. Jack Ponder.

Q All right. That's the same Jack Ponder who is still here with the company?

A That's right.

Q All right. Who else?

A Mr. W. F. Hachmeister.

Q How is that spelled?

A (Spelling) H-a-c-h-m-e-i-s-t-e-r.

[27] Q (By Mr. Pullen) There's a difference in reimbursement, is there not, if the subscriber goes to a participating pharmacist and if they go to a non-participating pharmacist?

A Yes, there is.

Q What is the difference?

A The non-participating pharmacies are not paid direct. Seventy-five percent is paid to the member or subscriber.

Q All right. What is the reason for the difference in treatment?

A I do not know.

Q Who would know that?

A I do not know.

Q All right. Do you have any idea as to who might within the company?

A Those who drafted the agreements.

Q All right. That you named previously?

A Right.

Q All right. Do you know if there were any studies made to determine the $2.00 figure as to whether it was appropriate or adequate or inadequate?

A No, I do not.

Excerpts from Deposition of Judith J. Johnson

Q Have there been any studies made since 1969 when this coverage was instituted here in Texas as to [28] whether the $2.00 figure is adequate or inadequate?

A No, not to my knowledge.

Q All right. Have there been any complaints received from the pharmacists who have executed the Participating Drug Pharmacy Agreement about any aspect of the agreement?

A Yes, there have been.

Q All right. What aspects did they complain about?

A Two dollar professional fee.

Q All right. What were their complaints?

A They indicated they did not feel it was adequate.

Q Did they give any indication what they thought was adequate?

A The amounts varied.

Q From what to what as best you can recall?

A As best I can recall from two twenty-five to three dollars.

Q The Medicare Part B claims, what do those involve; what type of coverage?

A Primarily physician and durable medical equipment. Those are the two primary—

Q Do they involve drugs in any manner?

A No, they do not.

* * * *

[32] Q What is the reason for having the Participating Drug Pharmacy Agreement which is Deposition Exhibit 1 with a pharmacist?

A Would you repeat the question, please?

MR. PULLEN: Would you read it back?

(The above question referred to was here read back by the Court Reporter.)

Excerpts from Deposition of Judith J. Johnson

THE WITNESS: May I consult with—
MR. PULLEN: Yes.

(A discussion was had off the record.)

THE WITNESS: I cannot testify to the reason.

Q (By Mr. Pullen) Does it serve any purpose in your opinion?

MR. KAISER: You are asking for her personal opinion or her opinion as a representative of the company?

MR. PULLEN: Both since you designated her as most familiar with it.

(A discussion was had off the record.)

THE WITNESS: Of course it is an agreement between Group Life and Health Insurance Company and individual pharmacy involved. To me the [33] purpose it serves is that they agree to deliver the benefits provided to that subscriber thereby servicing our subscriber.

Q (By Mr. Pullen) They could service him without signing the agreement, could they not?

A In my opinion we would not know that they were servicing them.

Q Well, pharmacists normally do fill prescriptions of people that come in and request them to do so, do they not?

A Usually.

Q Now, are you telling me that insofar as you know the only purpose for the Participating Drug Pharmacy Agreement which is Deposition Exhibit 1 is so that Group Life and Health Insurance Company will know that their subscribers are being serviced?

A Without giving you an assumption, yes.

Q All right. Why is it necessary again if you know to set out a professional dispensing fee in the Participating Drug Pharmacy Agreement?

Excerpts from Deposition of Judith J. Johnson

A As a part of the benefit provided through the contract with the subscribers to the best of my knowledge.

Q Now, what benefit do you refer to when you say that?

[34] A The benefit as described in the Participating Agreement.

Q Now, are you referring to Deposition Exhibit 1?

A Yes.

Q Does the subscriber ever see that or is that just between the pharmacist and Group Life and Health Insurance Company?

A That's merely between the pharmacy and Group Life and Health Insurance Company.

Q All right. So what the subscriber would see would be the contract between the subscriber and Group Life And Health Insurance Company, is that correct?

A That's correct.

Q All right.

(A discussion was had off the record.)

THE WITNESS: I was talking about the benefits as outlined in the contract with the subscriber.

Q (By Mr. Pullen) All right.

A That would be the same as those in the agreement.

Q All right. Why the difference in reimbursement of a participating pharmacist and a non-participating pharmacist?

[35] A I do not know.

Q It's not based on any quality of service provided by the pharmacist, is it?

A Not to my knowledge, no.

Q And as I understand it every pharmacist in the State of Texas was invited to and still may if they so

desire enter into a Participating Drug Pharmacy Agreement?

A That's right.

Q And there are no rules or regulations or criteria that Group Life And Health Insurance Company has as to who may enter into one of these agreements other than that fact that they must be duly licensed under the laws of the State of Texas as pharmacists?

MR. KAISER: I object to the form of the question. It's a statement.

Q (By Mr. Pullen) All right. Are there any rules or regulations or criteria with respect to pharmacists which would govern their executing a Participating Drug Pharmacy Agreement other than the fact that they must be duly licensed by the State of Texas?

A Not to my knowledge, no.

* * * *

[38] Q Do you have anything to do with sales of the prepaid drug prescription coverage to groups or individuals in the state?

A No, I do not.

Q All right. Who handles that?

A Marketing division.

Q What is the name of the individual?

A Mr. Hugh Eller (spelling) E-l-l-e-r.

Q Okay. Have you ever been told that a Participating Drug Pharmacy Agreement should be terminated with any pharmacist for any reason? By terminate I mean terminated by Group Life And Health Insurance Company.

A No, I have not.

Q Does Group Life or any of the Blue Cross-Blue Shield companies go into the particular pharmacist['s]

professional qualifications at all other than the requirement that they have a license?

A No, they do not.

Q Have there been any sales of the prepaid prescription drug coverage to any employer groups in San Antonio of which you are aware since the prepaid prescription coverage was first began?

A Yes, there have been.

* * * *

[40] Q Are there any other plans that Blue Cross-Blue Shield are involved in in Bexar County, Texas providing for prepaid prescription coverage?

A Not to my knowledge, no.

Q Do you know of any plans with the San Antonio Independent School District that Blue Cross-Blue Shield is involved in?

A Not to my knowledge.

Q All right. What happens if a pharmacist had signed a Participating Drug Pharmacy Agreement and he charges the subscriber more than the $2.00?

A If we were informed of it we would contact the pharmacy. To my knowledge that has not happened.

Q Is there any company policy about what would be done if the pharmacist said I'm going to charge more than the $2.00?

A It would be in violation of the contract.

* * * *

[49] Q All right. I'm going to ask the Reporter to leave a blank in the deposition and if you would would you tell us how many people were involved in the L.T.V. program as of the date of this letter?

MR. KAISER: Well now, would that be information that you would have in your office?

THE WITNESS: Not in my office. It would be available within the organization.

MR. KAISER: Okay. We'll find out and put it in.
45,961—as of August 22, 1974
MR. PULLEN: All right. Would you mark that?

(Deposition Exhibit Number 4 was marked for identification and a Xerox copy will be attached to the deposition.)

• • • •

[53] Q (By Mr. Pullen) Miss Johnson, I'm going to hand you what's been marked as Deposition Exhibit 7 which is a letter to Patts Drug Store dated December 30th, 1974, and ask you if you wrote the letter and if it was mailed back to you with the handwritten matter at the bottom and on the top of the next page.

A This is a routine letter that went out over my signature.

Q Do you recall receiving a copy back with the language at the bottom of the page and at the top of the following page?

A Yes, I do recall receiving it.

Q Now, if I may summarize and if I summarize it incorrectly please tell me; the language at the bottom is in handwriting which is apparently from Mr. Albert Papa. It states that he does not want to participate in the prepaid prescription drug program [54] because the fee is inadequate and does not take into consideration the different services that an individual pharmacy may perform. Is that not correct?

A Yes, that is correct.

Q Did you bring Mr. Papa's complaint to anyone's attention?

A I sent a carbon copy to Mr. Ray Pace.

Q All right. Now, who is Mr. Ray Pace?

A He's in our marketing division.

Q All right. Mr. Papa's complaint is accurate, is it not, in that a pharmacist who had signed Exhibit Number 1 got $2.00 no matter whether he performed merely the filling of the prescription or whether he delivered or whether he was open on various days?

MR. KAISER: I'll object to the question. The witness can't testify as to the accuracy of Mr. Papa's complaints. That's looking into the mental processes of one who wrote a document.

Q (By Mr. Pullen) The $2.00 fee applied to all pharmacies?

A That is correct.

Q It didn't matter what services they performed for their customer?

A That's correct.

Q The fee was not altered?

[55] A That's correct.

Q If it was a pharmacist where you drove up yourself and handed him the prescription and waited for it he would get $2.00 if he was a participating pharmacist and if he was called in and he had to deliver it he would still get $2.00?

A That's correct.

• • • •

[60] Q (By Mr. Pullen) Miss Johnson, I'm going to hand you Deposition Exhibit 12 which is an interoffice correspondence to Ray Pace from David Thigpen concerning Sommers Drug Store. I'll ask you to read the last line in that. Do you know what he was thanking you for?

A Yes, I do.

Q All right. What was it?

A I had received a telephone call—to the best of my recollection it was from Mr. Ray Pace indicating to me that Sommers had not received their letter.

Q Now, which letter are you referring to?

A Inviting them to become a participating pharmacy.

Q All right.

Excerpts from Deposition of Judith J. Johnson

MR. KAISER: Just a minute. I'll ask you, [61] Miss Johnson, are you referring to what's been marked as Deposition Exhibit Number 4?

THE WITNESS: Yes, I am. Therefore I had a copy made of the letter and sent it to Mr. Fred Holden asking that he have the letter delivered.

Q (By Mr. Pullen) All right.

A To the best of my recollection that is what he was thanking me for.

(Deposition Exhibit Number 13 was marked for identification and a Xerox copy will be attached to the deposition.)

Q (By Mr. Pullen) Miss Johnson, I'm also going to hand you Deposition Exhibit 13 which is an inter-office correspondence dated November 19, 1974, to you from David Thigpen and ask you if you've seen that?

A Yes, I have.

Q What does he refer to as the entire foundation program?

MR. KAISER: Well, if you know what he's referring to fine and if you don't tell Mr. Pullen.

(A discussion was had off the record.)

THE WITNESS: That's referring to the groups in San Antonio.

* * * *

[68] Q (By Mr. Pullen) Deposition Exhibit 21 appears to be a Participating Drug Pharmacy Agreement between Group Life And Health Insurance Company and Globe Stores, Inc., is that not correct?

A Yes, it is.

Q All right.

(Deposition Exhibit Number 22 was marked for identification and a Xerox copy will be attached to the deposition.)

Excerpts from Deposition of Judith J. Johnson

Q (By Mr. Pullen) Deposition Exhibit 22 appears to be the Participating Drug Pharmacy Agreement with Marvin Drug Company of Texas, is that not correct?

A Yes, it is.

Q Now, I notice that Exhibit 20, 22 and 19 all have the same billing address of 4300 Peterson Avenue, Chicago, Illinois. Do you know why they all use that same address?

A To the best of my knowledge they are all companies or subsidiaries of Walgreens.

* * * *

[83] Q (By Mr. Pullen) All right. I now hand you Deposition Exhibit 35 and ask you if you recall ever seeing that?

A I do not recall.

Q All right. Do you recall in dealing with SupeRx Drugs that they were headquartered in Cincinnati, Ohio?

A Yes, I do recall.

Q Is this where their claims would be submitted from and the checks sent to them from Blue Shield?

A I'm sorry. I don't remember.

MR. PULLEN: All right. I don't believe I have any further questions. Thank you very much.

CROSS EXAMINATION

BY MR. KAISER:

Q Miss Johnson, let me hand you what has previously been marked as Deposition Exhibit Number 4 and I'll ask you if that is a standard letter that is sent out to all pharmacies as far as the text is concerned?

A Yes, it is.

Q Well, do you receive them in printed condition [84] with respect to the text?

Excerpts from Deposition of Judith J. Johnson

A We did on this particular mailing because it was mass mailing. The others are individually typed—the variation being the opening paragraph.

Q All right. With respect to this letter marked as Exhibit 4 what would be the difference in the letter that was received by, say, X Drug Store in San Antonio? My question is would there be any difference in the letter except for the address block?

A No.

Q Let me hand you what has been marked as Deposition Exhibit Number 9. Is that a standard form letter that is sent out or was sent out by your office?

A It was sent out by Dr. Ferguson in 1969.

Q Well, my question is was that a standard form letter that was sent out to many pharmacies?

A Yes, it was.

Q I hand you Deposition Exhibit Number 10. Would that also be a standard form letter that was sent out?

A Yes.

* * * *

BLUE SHIELD OF TEXAS FORM LETTER AND ENCLOSURES (PARTICIPATING DRUG PHARMACY AGREEMENT, DRUG MANUAL, DECAL AND FORMS) ("EXHIBIT 2" TO DEPOSITION OF JUDITH M. JOHNSON, NOVEMBER 20, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

BLUE CROSS
BLUE SHIELD
OF TEXAS

[LOGOS]

Louis W. Conradt, M.D.
Associate Medical Director
214/741-8764

Ernest A. Maxwell, M.D.
Vice President, Medical Director

Post Office Box 22001
Dallas, Texas 75222
214/741-8751

Date

Store Name
Address
City, State, Zip

Gentlemen:

Enclosed is your signed copy of the Participating Drug Pharmacy Agreement, a drug manual, decal and a supply of forms. Also enclosed is your plastic identification card, which is to be used in your Data Recorder Machine (Master Charge, Bankamericard or Vendor Drug Program) to insert your identification information on the claim form. In conjunction with the pharmacy's plastic identification card, each Blue Shield member who is covered by the

Blue Shield of Texas Form Letter, etc.

Blue Shield Prescription Drug Progam will be issued a plastic identification card, which is to be used separately in the Data Recorder to imprint the member's name, group and identification numbers.

Thank you for your participation and cooperation.

Sincerely,

Judy Johnson, Assistant Vice President,
Medical Administration

JJ:cw
enclosures

Blue Shield of Texas Form Letter, etc.

BLUE CROSS
BLUE SHIELD
OF TEXAS

[LOGOS]

Louis W. Conradt, M.D.
Associate Medical Director
214/741-8764

Ernest A. Maxwell, M.D.
Vice President, Medical Director

Post Office Box 22001
Dallas, Texas 75222
214/741-8751

Date

Store Name (Chain)
Address
City, State, Zip

Gentlemen:

Enclosed is a drug manual, decal and a supply of forms. Also enclosed is your plastic identification card, which is to be used in your Data Recorder Machine (Master Charge, Bankamericard or Vendor Drug Program) to insert your identification information on the claim form. In conjunction with the pharmacy's plastic identification card, each Blue Shield member who is covered by the Blue Shield Prescription Drug Program will be issued a plastic identification card, which is to be used separately in the Data Recorder to imprint the member's name, group and identification numbers.

Thank you for your participation and cooperation.

Sincerely,

Judy Johnson, Assistant Vice President,
Medical Administration

JJ:cw
enclosures

TEXAS BLUE SHIELD® PRESCRIPTION DRUG PROGRAM

® R.T.M. of NABSP

Revised 8-1-72

FOREWORD

This manual is intended to supplement your Participation Agreement and to acquaint you with the Blue Shield Prescription Drug Program benefits and procedures. While it is not a legal basis for interpreting our contracts, it is a comprehensive instructional guide for billing procedures and other Blue Shield matters.

Blue Shield will, from time to time, send you new pages for insertion to keep you informed of changes.

Blue Shield of Texas Form Letter, etc.

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Prescription Drug Program Participation Agreement

WELCOME TO THE BLUE CROSS AND BLUE SHIELD "FAMILY"

We are very glad to have you as a Participating Pharmacy in the Blue Shield Prescription Drug Program. It is our hope that in this joint effort we will work together in mutual understanding and harmony and that together we will be able to serve the health care needs of the community more effectively.

We value highly the relationship that we enjoy with all of our providers. It is for this reason that we have in our organization a Medical Division for the purpose of maintaining and improving relations with the various providers of the health care delivery system. The men who head up the division are physicians. The Professional Relations Representatives who assist them are highly skilled and knowledgeable in the health care field. These men are here to help serve you.

DESCRIPTION OF PRESCRIPTION DRUG PROGRAM

The Texas Blue Shield Prescription Drug Program has extended coverage to Subscribers (employees) of certain groups who have been issued Blue Cross Blue Shield identification cards indicating that the subscriber and his dependents are covered under this Program. Blue Shield has guaranteed the subscriber his free choice in selecting a pharmacist to provide pharmaceutical services under this Program. This Program will allow the pharmacist to provide the most comprehensive services to the patient, and will provide ease in billing and post auditing. Patients with drug benefits under their Blue Shield contract will present a Blue Cross-Blue Shield Identification Card when requesting services.

DEFINITIONS

Acquisition Cost—The actual invoice cost of a drug with the exception of cash discounts, but including trade discounts, such as quantity, rebates, price concessions, etc. to the provider or to the company, organization or its affiliates with which the Provider is associated, whichever is less.

Explanation:

This definition recognizes that the actual cost of a drug to certain large chain stores, hospital, etc. is often less than the cost to other Providers. Consequently, the cost of the drug to the company or organization will be used rather than the cost to the establishment or individual actually dispensing the drug.

Cash discounts allow a reduction from invoice price for prompt payment. Cash discounts are not considered in determining the actual invoice cost. Trade discounts allow reductions from invoice price without regard to date of payment. Discounts given for quantities purchased or for items purchased at a time other than when they are in high demand are examples of trade discounts. Trade discounts are considered in determining the actual invoice cost.

Providers sometimes receive discounts in the form of cash rebates from a supplier based on the dollar volume purchased during a given period of time. To the degree possible, such rebates are to be considered in the determination of Acquisition Cost.

Co-Payment (Also Called "Drug Deductible") Amount—An amount, to be paid by a subscriber for each separate Prescription Order and refill or a Covered Drug, not to exceed $2.00.

Explanation:

For drugs dispensed by a Participating Provider the subscriber will not, for any reason (such as sales tax, delivery charge, etc.), be required to pay any amount in addition to the Co-Payment Amount.

The Co-Payment Amount of $2.00 will be used by Blue Shield for determining the amount of benefit payment to the Provider.

Covered Drug—Injectable insulin or any Prescription Legend Drug or any medication compounded by the Provider which contains a Prescription Legend Drug provided that the drug is ordered by a Physician or Dentist; is one for which a written Prescription Order is customarily prepared; is one for which a separate Usual and Customary charge of $2.00 or more is normally made and is one which is not entirely consumed at the time and place of the Prescription Order. Contraceptive Medications are not a covered drug.

Explanation:

Compounded medications which contain a Prescription Legend Drug are not always required to bear the legend "Caution: Federal Law prohibits dispensing without a prescription." However, when a Provider prepares, pursuant to a Prescription Order, a compounded medication in which at least one ingredient is a Prescription Legend Drug, the compounded medication is a Covered Drug if it meets the other requirements in the definition of a Covered Drug.

The two phrases ". . . for which a written Prescription Order is customarily prepared . . ." and ". . . and which is not entirely consumed at the time and place of the Prescription Order . . ." exclude from the program drugs administered and entirely consumed

in connection with care rendered in the home and office.

Any drug for which the Provider's Usual and Customary Charge is less than $2.00 is *not* a Covered Drug under the Program.

A drug requiring a prescription by State, but not Federal Law, is *not* a Covered Drug. This program pays for Covered Drugs only.

Provider—A Pharmacy, Pharmacist, Physician, Dentist or any other person or organization legally licensed to dispense drugs.

Pharmacy—A licensed establishment where Prescription Legend Drugs are dispensed by a Pharmacist.

Non-Participating Provider—A Provider who has not entered into a Participation Agreement with Blue Shield.

Participating Provider—A Provider who has entered into a Participating Contract with Blue Shield of Texas to provide a Covered Drug at a cost to a subscriber not to exceed the Co-Payment Amount of $2.00 and a total payment from Blue Shield and the subscriber not to exceed the cost of the Covered Drug plus a dispensing fee.

Prescription Legend Drug—Any medicinal substance—the label of which, under the Federal Food, Drug, and Cosmetic Act is required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription."

Prescription Order—A written or oral request by a Physician or Dentist for a single Prescription Legend Drug.

Explanation:

While injectable insulin is not a Prescription Legend Drug and does not require a Prescription Order, it is a Covered Drug under this Program.

Dispensing Fee—An amount or amounts predetermined by Blue Shield to compensate Participating Providers for dispensing Covered Drugs.

Any applicable sales tax is to be considered as included in the Dispensing Fee. For this Drug Program, the dispensing fee is $2.00.

Prescription Charges—For a Participating Provider, Prescription Charges means the Acquisition Cost plus the Dispensing Fee for a Covered Drug except for injectable insulin. In the case of injectable insulin, Prescription Charges means the Usual and Customary Charge or the Acquisition Cost plus the Dispensing Fee, whichever is lower. For a Non-Participating Provider, Prescription Charges means the Usual and Customary Charge for a covered drug.

For a Provider out of the State of Texas, Prescription Charges means the Usual and Customary Charge for a Covered Drug.

Usual and Customary Charges—When determined by Blue Shield to be a reasonable amount, the Usual and Customary Charge is the amount, including sales tax, actually charged by: (1) a Participating Provider for injectable insulin; (2) a Non-Participating Provider for a Covered Drug; or (3) a Provider out of the State of Texas for a Covered Drug.

Explanation:

In determining what constitutes a reasonable amount, Blue Shield will take into consideration:

a. The amount which the Provider most frequently charges the majority of recipients for the Covered Drug;

b. The range of charges by other Providers for the Covered Drug.

Utilization Record—A record of all claims submitted to and paid by Blue Shield for a subscriber and his eligible dependents.

Physician—One who is legally qualified and licensed to practice medicine and perform surgery at the time and place services are rendered; and for the purpose of this program, a doctor of medicine, a doctor of osteopathy, or a podiatrist who is legally licensed to prescribe medications within a scope of that license.

Dentist—A doctor of dental surgery or a doctor of dental medicine legally licensed to prescribe medications within the scope of that license.

Pharmacist—A person licensed to dispense Prescription Legend Drugs under the laws of the State of Texas.

Member or Subscriber—An employee who is covered by this Drug Program issued to his employer.

Dependent—Only a subscriber's spouse and any unmarried child who is either under twenty-five years of age or totally and permanently disabled, for whose covered application has been made by the subscriber and accepted by the Insurer; provided that, in the case of a child who is over nineteen years of age and is either under the age of twenty-five or totally and permanently disabled, he is legally residing with and dependent upon the subscriber for more than one-half of his support as defined by the Internal Revenue Code of the United States. In the case of any child over twenty-five years of age who is determined by the Insurer to be totally and permanently disabled, the Insurer shall have the right to require periodic certification of the child's physical condition from the subscriber as a condition to the continued coverage of the child as a Dependent. "Totally and permanently disabled" means any medically determinable physical or mental con-

dition which prevents the child from engaging in substantial, gainful activity and which can be expected to result in death or to be of long-continued or indefinite duration.

BENEFITS UNDER THE PROGRAM

The Texas Blue Shield Prescription Drug Program will pay for Insulin and all Drugs which bear the Federally required legend, "Caution: Federal Law prohibits dispensing without a prescription," except contraceptives, obtained by and for the use of a member in accord with the conditions in this manual on the date the service is performed. In order to be a Covered Drug there must be a prescription by a physician or dentist; must not be entirely consumed at the time and place that the Prescription Order is given; must be one for which a separate charge is customarily made; and must be one for which a written Prescription Order is customarily prepared; and must be one for which the charge exceeds the deductible. Benefits shall be provided for Covered Drugs prescribed on and after the effective date of this Program of October 1, 1969, even though the Prescription Order may have been issued prior to the effective date.

Explanation:

By definition, a Prescription Legend Drug is any medicinal substance which under the Federal Food, Drug and Cosmetic Act is required to carry on its label the legend, "Caution: Federal Law prohibits dispensing without a prescription." A Legend Drug, then, cannot be dispensed without a prescription. Aspirin tablets or any medication which can be purchased at a drug store without a prescription from a doctor or dentist are not considered Prescription Legend Drugs. Drugs which require a prescription under State law but not under Federal law are not

covered. Paregoric, by Texas law requires a prescription when more than one ounce is dispensed. The Drug Program will provide benefits for this drug as long as the charge exceeds the $2.00 co-payment amount. Drugs such as Penicillin and Sulfa, which under Federal Law require a prescription order, are Prescription Legend Drugs and are covered.

A compounded medication is also a "covered" drug if it contains a Prescription Legend Drug. A compounded medication refers only to a medication which is compounded by the pharmacist (or Provider). A drug in its final form, which is a compound, [which] requires no mixing by the Provider is therefore, not a compounded medication. A compounded medication which includes at least one Prescription Legend Drug as one of its ingredients, is not required to carry the Legend: "Caution, Federal Law Prohibits Dispensing without a Prescription", but is a covered drug. However, a compounded medication is covered only with a prescription order from a doctor or dentist.

Injectable Insulin is the only injectable drug which can be dispensed without a prescription order from a doctor or dentist. Used in the control of diabetes, this drug in its injectable form can be sold "across the counter". The reason for this is obvious. To the diabetic, the availability of Injectable Insulin in an emergency could mean the difference between life and death. This Drug Program will cover Injectable Insulin for this reason.

This program will not interfere with the right of the pharmacist to exercise professional judgment. A participating pharmacist is under no obligation to dispense a prescription order which, in his professional opinion, should not be dispensed. Should the physician elect to

prescribe in generic form, the pharmacist shall dispense the lowest cost drug in stock which meets official compendium specifications, and which, in his professional opinion, fulfills the physician's requirements. See Exclusions.

Quantity of Medication

The maximum supply of medication allowed in this program will be 34 days except that the plan will pay for 100 unit doses (e.g., tablets or capsules) of a natural thyroid product and 100 unit doses of Nitroglycerine, and Maintenance Legend Drugs (Stabilizing Drugs). Payment will be made for authorized prescription refills, not to extend beyond one year from the date of the original order.

Explanation:

For example, a doctor discovers that a subscriber has a severe iron deficiency. He gave a non-refillable prescription for an iron capsule which is to be taken once a day for 2 months. We will assume that the iron capsule prescribed is a "covered" drug. If the Prescription Order indicates a 60 day supply of medication (2 months), the Prescription Drug Program would only pay for a 34 day supply or in this case, 34 iron capsules (minus the Co-payment Amount, etc.).

If the prescription order indicated one refill, Blue Shield would pay for 34 iron capsules on the original prescription order and 34 additional iron capsules when the prescription was refilled.

This "34 day supply" limitation is waived for nitroglycerin, natural thyroid product, and Maintenance Legend Drugs (Stabilizing Drugs). In the case of these drugs, 100 unit doses (100 capsules, 100 tablets, etc.) will be covered with a prescription order for 60 nitroglycerin tablets (one a day for 2 months) or 60 thyroid pills, or Maintenance Legend Drugs Blue Shield would cover the full 60 day supply (minus the Co-payment Amount, etc.).

The Dispensing Fee

The Texas Blue Shield dispensing fee for pharmaceutical service is $2.00.

Co-Payments (Drug Deductible)

The co-payment (drug deductible) for the Texas Blue Shield Prescription Drug Program is $2.00.

Payment

Participating Pharmacist: Payment to the Provider will be made in accordance with the Participation Agreement.

The Provider has agreed:

1. To charge as payment in full for a covered drug, his acquisition cost plus a dispensing fee of $2.00.
2. To charge the subscriber no more than the co-payment amount or deductible which is $2.00.

Blue Shield has agreed:

To pay a participating Provider as payment for a covered drug, acquisition cost plus a dispensing fee less the deductible.

If a Provider is in doubt as to whether a person is an eligible subscriber or eligible dependent, the provider will charge his acquisition cost plus the dispensing fee, complete the claim form and collect the appropriate amount from the questionable subscriber.

Explanation:

For example, a subscriber presents a covered drug prescription to a participating provider but does not have an appropriate identification card to demonstrate his eligibility. The provider does not want to assume the risk of filling the prescription and having that prescription rejected by Blue Shield. Accordingly, the provider would fill the prescription, complete the form so it will enable the subscriber to receive from Blue Shield a payment of the drug acquisition cost plus a dispensing fee, less the deductible. The provider will collect his cost plus a dispensing fee from the subscriber.

Non-Participating Pharmacist: No payment will be made under this program to a non-participating pharmacist. There is a provision to pay to the member on a reimbursement basis for some of his costs for covered drugs. Insulin will be paid on the basis of the usual and customary charge to the public, or on the basis of acquisition cost plus dispensing fee, whichever is less.

Explanation:

Example
Participating Provider
Injectable Insulin
(4 Vials of U-40 Insulin)

#1		#2	
Acquisition Cost	$4.00	Usual & Customary	$5.00
Plus Dispensing Fee	±2.00	(No Dispensing Fee)	—
Equals the Prescription Charges of	$6.00	Total Prescription Charges	$5.00
Less Co-Payment	−2.00	Less Co-Payment	−2.00
Equals the Payment to Provider	$4.00	Equals the Payment to Provider	$3.00

In the example on injectable insulin, Blue Shield will pay a Participating Provider according to #2 because the Usual and Customary charge method results in a lower prescription Charge than does the Acquisition Cost plus the Dispensing Fee method.

EXCLUSIONS

The following are not to be included as allowable benefits under the Texas Blue Shield Prescription Drug Program:

A. No benefit shall be available to a member if he is entitled to receive reimbursement under Workmen's Compensation laws or is entitled to coverage from any municipal, State or Federal Program, whether contributory or not.

B. Any charge for a contraceptive medication, even if such medication is a Prescription Legend Drug.

C. Any charge for therapeutic devices or appliances (e.g., hypodermic needles, syringes, support garments, and other non-medical substances) regardless of their intended use.

D. Any charge for administration of Prescription Legend Drugs and injectable insulin.

E. The charge for medications furnished on an inpatient basis. (Drugs furnished while a bed-patient in a hospital.)

F. The charge for medications furnished on an outpatient basis where coverage is furnished under any other Blue Cross and/or Blue Shield contract or any other carrier providing group coverage to the extent the payment duplicates the benefits of the other coverage, subject to a coordination of benefits provision.

G. The charge for more than a 34 day supply of a medication, except that the Program will cover 100 unit doses (e.g., tablet or capsule, etc.) of a natural thyroid product and 100 unit doses of nitroglycerine and Maintenance Legend Drugs (Stabilizing Drugs).

H. The charge for any prescription refill in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's order.

I. Drugs for which the provider customarily charges less than the co-payment amount.

J. Any drug for which a separate charge is not customarily made.

K. Any drug consumed at the time and place of the Prescription Order.

L. Any drug which is not required under Federal Law to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription" regardless of state laws.

M. Drugs dispensed prior to the effective date of this program.

CLAIMS ADMINISTRATION

Valid Identification Card

Persons eligible for the Prescription Drug Program will be issued plastic cards as depicted below. Note especially the three items pointed out to assure a current and valid card. The following are examples of the current I.D. cards for the Prescription Drug Program.

[Identification Cards Omitted in Printing]

Blue Shield of Texas will be issuing a plastic I.D. card for Texas Prescription Drug Program members. The new claim form is so designed to accommodate this card. Also, almost every type of imprinter can be used for this card and claim form. Follow the instructions for your imprinter to imprint the I.D. card information on the claim form.

IMPORTANT NOTE

The member will still carry the paper I.D. cards to use in filing other professional services. The group number and I.D. number is identical on both cards, therefore, either card should give the correct membership information.

[Identification Card Omitted in Printing]

The new claim form will not be preprinted with your Blue Shield provider number and address; however, each Participating Pharmacy will be issued a plastic identification card. The I.D. card should be used with an imprinter to give the pharmacy identification information required on the claim form. Upon request, a replacement will be furnished.

[Identification Cards Omitted in Printing]

SEE EXPLANATION ON REVERSE SIDE OF COPY 2

GROUP

PAYMENT DUE MEMBER (SHOW ADDRESS)

PAYMENT DUE PHARMACY

PHARMACY IS NON-PARTICIPATING

(SHOW NPP'S ADDRESS)

BLUE SHIELD OF TEXAS
PRESCRIPTION DRUG PROGRAM

CLAIM NO

BLUE SHIELD USE ONLY ▶ | BSD NO | BLUE SHIELD CONTROL NUMBER | N/C CODE | DATE PAID

DATE DISPENSED | PRESCRIPTION NUMBER | METRIC QUANTITY DISP

EACH CC GM | REFILL | DAYS SUPPLY

NATIONAL DRUG CODE | CMPD

PRODUCT COST(S)

TOTAL

DRUG | MFR | AMOUNT DUE

STRENGTH | DOSAGE FORM

PATIENT INFORMATION

FIRST NAME | AGE | SEX (CHECK) M ☐ F ☐

PATIENT IS ☐ SUBSCRIBER ☐ SPOUSE ☐ CHILD ☐ OTHER

I certify that the service described hereon has been provided in accordance with the Participating Drug Pharmacy Agreement with Blue Shield of Texas.

X

SIGNATURE OF PHARMACIST

X

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

Mail last copy to: BLUE SHIELD OF TEXAS
BOX 22284
DALLAS, TEXAS 75222
TELEPHONE 741 3761

PORTANT NOTICE TO MEMBER When payment is to be made to the member the Prescription Information Section should be completed by the Pharmacy
/hen payment is to be made to the Member, be sure to include Member's complete address.
/hen pharmacy is Non Participating, be sure to include Member's complete address.

SCRIPTION INFORMATION SECTION:

ray shaded area is for Blue Shield use only. Do not fill in.

etric Quantity – the number of units dispensed; i.e., 10 cc, 100 tablets, etc

efill – Indicate the number of times the prescription has been refilled Enter "0" if it is the original prescription.

ational Drug Code – ONLY LEGEND DRUGS ELIGIBLE FOR BENEFITS If drug dispensed has not been assigned a National Drug Code, leave this blank and enter a complete description in the space below the drug code block

ompound – check this box if prescription dispensed was a compounded drug. List all components of a compounded prescription in the area below "CMPD" box.

roduct Cost (Acquisition Cost) – actual invoice cost of drug dispensed (including trade discounts but not cash discounts) to your pharmacy or to the organization or its affiliates with which the pharmacy is associated, whichever is less.

harmacy Charge (Professional Fee) – PARTICIPATING PHARMACY ONLY – current professional fee payable to Texas Blue Shield Participating Pharmacies for pharmaceutical services is $2.00.

o-Pay or Deductible – the co-pay (deductible) amount is $2.00 for each prescription.

mount Due – add total prescription charge to member (acquisition cost + professional fee) less the co pay amount

Claim Forms

The payment of a drug claim by Blue Shield of Texas is dependent upon the information shown on the claim form. This form has been designed to provide rapid reimbursement and a minimum of paper work for you. Your attention is directed to our request that the entries by carefully handwritten, which will expedite claims payment and minimize delay of claims payment. The data is used to determine such items as contract eligibility, drugs cost and utilization and is, consequently, vital to the processing of a claim.

There is one type claim form. #304

When payment is due to the Pharmacy or Member, this claim form is used.

The use and completion of the claim form is dependent upon several factors. In the following discussion, reference to a "pharmacy" should be read as "pharmacy (or provider)."

1. PRESCRIPTION DRUG PROGRAM CLAIMS FORM #304

When a participating pharmacy is requesting payment for a prescription drug, this claim form should be completed according to the instructions listed on the reverse side of the claim form.

Whenever a participating pharmacy dispenses a "covered" drug, the recipient of that drug is responsible ONLY for the co-payment amount. Once the pharmacy submits a claim to Blue Shield, the balance due (Acquisition Cost and Professional Fee—Co-payment Amount) is paid directly to that PHARMACY, NOT TO THE RECIPIENT.

**The claim form is always completed in duplicate.

** THE FIRST COPY is retained by the Pharmacy for record purposes. This claim form serves a dual purpose in that it can be used for both Pay Pharmacy and Pay Member.

** THE SECOND COPY is sent to Blue Shield of Texas. The members' name, group, and I.D. numbers may be obtained from the paper or plastic I.D. card. With the plastic I.D. card, any type of imprinter may be used to imprint this information on the form. Also, the pharmacy's I.D. information may be imprinted on the claim form by using your plastic I.D. card with an imprinter or by printing this information.

PAYMENT TO SUBSCRIBER—CLAIM FORM #304

Form #304 is also used when payment is due to the member. This form should be used when a "covered" drug(s) is dispensed by a

a. *Non-participating pharmacy*, or an

b. *Out-of-state pharmacy*, or, under certain conditions, by a

c. *Participating pharmacy.*

Once the claim is processed by Blue Shield of Texas and is found to be valid, payment for the claim will be sent directly to the subscriber.

Payment is due to the member when the subscriber has already paid the pharmacy in full for his prescription.

The form is always completed in duplicate.

* THE FIRST COPY is retained by the subscriber for record purposes.

* THE SECOND COPY is sent to Blue Shield of Texas.

The subscriber should carefully print the member's name, address, certificate and group numbers; the patient's name, age and relationship to the member must also be included. The subscriber must request the Pharmacist to complete that portion of the claim form so denoted. IMPORTANT: The claim form *must* be signed by the subscriber and the pharmacist. If an imprinter is available, the plastic ID card may be used to give the member's name, group and certificate number. The address will need to be written in when payment is being made to subscriber.

a. *Non-participating Pharmacy*

When an eligible subscriber receives services from a non-participating pharmacy, Blue Shield of Texas will pay the subscriber 75% of the pharmacy's Usual and Customary charge after first deducting the co-payment liability of the patient.

EXAMPLE: If a non-participating pharmacy charges a Usual and Customary fee of $8.00 for certain "covered" drugs, the reimbursement to the subscriber would be determined as follows, assuming the co-payment is $2.00.

Charge	$8.00
Less Co-Payment Amount	2.00
	6.00
Multiplied by 75%	.75
Payment to Subscriber	$4.50

b. *Out-of-State Pharmacy*

When an eligible subscriber receives services from an out-of-state pharmacy, Blue Shield of Texas will pay the subscriber 100% of the pharmacy's Usual and Customary charge less the co-pay amount.

EXAMPLE: The out-of-state pharmacy's Usual and Customary charge for a certain prescription is $6.00. The reimbursement to the subscriber would be as follows:

Usual and Customary Charge	$6.00
Less Co-Payment Amount	2.00
Amount Due Subscriber	$4.00

c. *Participating Pharmacy*

IF a participating pharmacy is uncertain about a patient's drug eligibility coverage, the subscriber should be questioned accordingly. If after questioning, there is still an uncertainty, the subscriber will be charged the full amount for the drug and the pharmacy should assist in filling out a claim form. It is important that the participating pharmacy denote his assigned Blue Shield account number in the space provided on the claim form.

When Blue Shield of Texas audits the claim and determines that the subscriber is indeed eligible, the subscriber would then be reimbursed for 100% of the pharmacy's charge after deduction of the co-payment.

Additionally, the pharmacy's charge will be determined in a manner identical to a Due Pharmacy claim schedule, i.e., (Acquisition Cost + Professional Fee).

One example of the above situation would be when a subscriber is covered but has not yet received his I.D. card.

Filling Out The Claim Form

The subscriber should fill out the left portion of the form and then have the Pharmacist fill out his portion.

Blue Shield of Texas Form Letter, etc.

The subscriber and the pharmacist then sign the form prior to submitting it to Blue Shield of Texas. Your plastic pharmacy I.D. card along with the subscriber's plastic I.D. card may be used for identification section of form by using an imprinter.

EXAMPLE OF A SUBSCRIBER CLAIM

Patient Mary Doe (spouse of member John Doe) takes one prescription to a pharmacy. After filling the prescription the Pharmacist determines the charges, collects the appropriate amount from the subscriber, and assists in filling out the claim form.

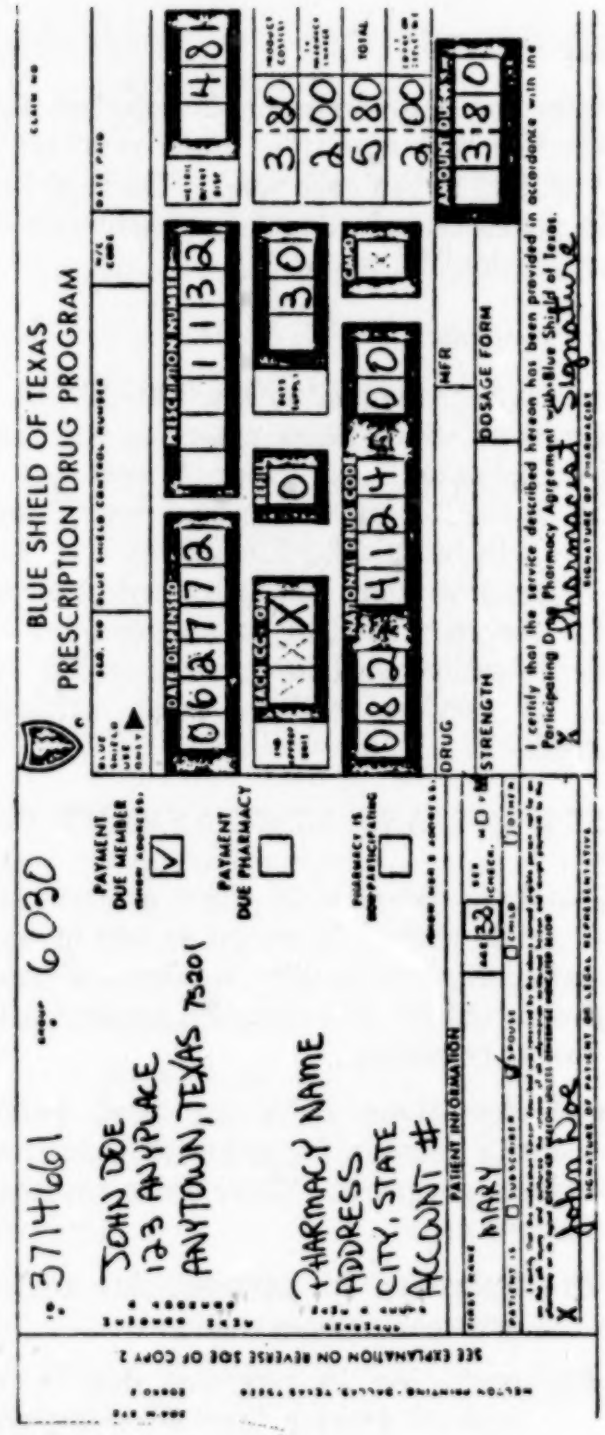
* The following date and example is for illustration only and does not intend any actual suggested prescriptions or costs.

Example

Prescription No. 1	Prescription No. is 1132 Original (as opposed to being a refill). 48 capsules of Cyclospasmol—200 mg.

All of the information required for completion of a "Payment to Pharmacy claim" is needed. In addition, please check the Payment Due Member box. If box is not checked and the claim is received from a participating pharmacy, payment will be sent to the pharmacy. Never file a claim for the payment to be sent to subscriber, unless the member has paid the charge in full and there is reasonable doubt of eligibility. (See Paragraph C, under Payment To Subscriber—Claim Form #304). *Always give member's address when filing a subscriber claim.*

Blue Shield of Texas Form Letter, etc.



Reject Codes

When a claim for a prescription is rejected, the reason for this rejection will appear on your remittance advice (payment) mailed to you each week. The reject codes can be found in your manual (See Adjustment and Non-Payment Codes, Section V).

Good Faith Provision

If a pharmacist is presented with a Blue Shield of Texas identification card which bears a service code and group number that indicate Drug Program coverage, and, on the basis of that card renders contract benefit services in good faith, he will be paid for his services. If Blue Shield of Texas determines that the I.D. card was not valid, payment for that service will be accompanied by notice that the identification card in question is not valid, and that claims for services rendered after notification will not be honored.

ADJUSTMENT AND NON-PAYMENT CODES

Code 22—No drug coverage in effect on date of service. Possible change in group or use of an identification card no longer in effect. Future claims submitted for this contract number will be subject to rejection.

Adjustment Codes—these codes are used primarily to identify reasons for payment reductions in the pricing programs. These codes and their explanations are:

(a) 01—Reduction in payment due to invalid or erroneous co-pay amount.

(b) 02—Reduction in payment due to requested amount greater than allowed payment.

(c) 03—Reduction in payment resulting from subscriber liability.

Non-Payment (N.P.) Codes—the following codes indicate various reasons why no payment is being made on this particular claim.

(a) 04—No contract in effect on date of service.

(b) 50—Duplicate of prior claim.

(c) 51—Duplicate of rejected claim.

(d) 54—Prescription drugs.

(e) 59—Drug Code indicates ineligible prescription drug program service.

(f) 92—This contract previously flagged as "22"—contract no longer eligible for prescription drug benefits.

MISCELLANEOUS INFORMATION

Ordering Forms

Prescription Drug Program Claims Form #304 will be supplied by Blue Cross and Blue Shield for use by the Participating Pharmacy to submit claims for payment in the Prescription Drug Program. You may obtain these forms by mailing your request to:

Blue Cross and Blue Shield
P. O. Box 22284
Dallas, Texas 75201

For Information

Claims will be processed in the Blue Shield Dallas Office, however, some information will be available in our local offices. A listing of these offices is on Page V-4. If you need information from the Dallas Office, write Texas Blue

Cross and Blue Shield or phone this Dallas number, 741-3761, Area Code 214, and ask for the appropriate extension.

Eligibility
Subscribers Accounts Dept ..... Ext. 305

Claims Reporting and Payments
Blue Shield Claims Section ..... Ext. 513
LTV Claims Section ..... Ext. 465

Professional Questions
Medical Division ..... Ext. 228

Acquisition Cost or Audit Information
Comptroller Department ..... Ext. 321

When calling about a specific claim, please have available the patient's identification number and any other pertinent information relating to that claim.

Advertising

The Participating Pharmacy agrees not to engage in any advertising relative to the Blue Shield Prescription Drug Program without prior approval of Texas Blue Shield. Blue Shield will supply window decals to identify Participating Pharmacies. The decals will be 6" x 8".

Reproduction of four-color window decal — shown actual size.

BLUE SHIELD

GROUP LIFE & HEALTH INSURANCE CO.

PARTICIPATING PHARMACY

An affiliate of

BLUE CROSS of Texas

Blue Shield of Texas Form Letter, etc.

HOME OFFICE: Main at North Central, Dallas, Texas 75222
741-3761

18 DISTRICT OFFICES TO SERVE YOU

Abilene 677-2671
Suite 206, Bank of Commerce Bldg.
Abilene, Texas 79605

Amarillo 372-1238
528 Amarillo Petroleum Bldg.
Amarillo, Texas 79101

Austin 452-0661
6225 U.S. Hwy. 290 East
Austin, Texas 78723

Beaumont 832-2589
1101 Beaumont Savings Bldg.
Beaumont, Texas 77701

Corpus Christi 882-5659
Guaranty Bank Plaza
726 Leopard Street
Corpus Christi, Texas 78401

El Paso 533-5525
1008 El Paso Natl. Bank Bldg.
El Paso, Texas 79901

Fort Worth 335-9315
507 Continental Life Bldg.
Fort Worth, Texas 76102

Harlingen 423-0474
Harlingen Natl. Bank Bldg.
Harlingen, Texas 78550

Houston 526-4962
5619 Fannin St.
Houston, Texas 77004

Longview 753-0311
425 First Natl. Bank Bldg.
Longview, Texas 75601

Lubbock 763-7094
Suite 211, Court Place Bldg.
Lubbock, Texas 79408

Lufkin 632-6605
606 East Lufkin Avenue
Home Savings & Loan Bldg.
Lufkin, Texas 75901

Midland 684-6644
210 First Savings & Loan Bldg.
Midland, Texas 79701

San Angelo 653-2951
San Angelo Natl. Bank Bldg., Suite 205
San Angelo, Texas 76901

San Antonio 342-9358
Exchange Plaza Bldg.
8010 Vantage
San Antonio, Texas 78230

Tyler 592-7321
East Texas Savings & Loan Bldg.
Room 201
Tyler, Texas 75701

Waco 772-7200
6501 Sanger, Suite 18
Waco, Texas 76710

Wichita Falls 723-8197
712 First Wichita Natl. Bank Bldg.
Wichita Falls, Texas 76301

Blue Shield of Texas Form Letter, etc.

Blue Shield
GROUP LIFE & HEALTH INSURANCE CO

PARTICIPATING
PHARMACY

An Affiliate of
Blue Cross of Texas

LETTER FROM ERNEST A. MAXWELL TO THE SOMMERS DRUG COMPANY, DATED OCTOBER 9, 1974 ("EXHIBIT 4" TO DEPOSITION OF JUDITH M. JOHNSON, NOVEMBER 20, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

October 9, 1974

Sommers Drug Company
3130 East Houston
San Antonio, Texas

Gentlemen:

For several years, Blue Shield of Texas has offered a Prepaid Prescription Drug Program which we plan to expand. The following paragraphs generally outline the benefits offered to participating pharmacies under this Program.

Under this Program the benefits to a participating pharmacy are the cost of a drug dispensed to an eligible employee, plus a dispensing fee of $2.00. The first $2.00 of drug cost is paid by the employee at the time the prescription is filled; Texas Blue Cross and Blue Shield will pay the remaining drug cost plus a dispensing fee of $2.00. The employee is required to present an Identification Card which will prove his eligibility.

Only those drugs which under Federal Law are required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription" are covered under this program. Excluded is any drug whose cost is less than $2.00, contraceptive drugs, and drugs for which no charge is customarily made. The limit on quantity is a 34-day supply of a covered drug except in the case of natural thyroid products or nitroglycerin, a limit of 100 unit doses.

Letter From Ernest A. Maxwell

You may participate in this Program by completing both of the attached Participating Drug Pharmacy Agreements and mailing them to Blue Cross and Blue Shield of Texas, P.O. Box 22001, Dallas, Texas 75222. One executed agreement will be returned to you. In completing this form, be sure that all requested information is given. Each corporate or individual owner of a pharmacy or pharmacies must complete a Participating Agreement in order to participate.

If you or your corporation own multiple pharmacies and you wish your checks sent to a central billing office, only one Agreement should be completed. Place the name of your participating pharmacy and the billing address in the spaces provided. On a separate sheet of paper, list the address of each pharmacy and permit number and list the names of the pharmacists employed at each store location.

When we receive the Participating Agreements we will send you a window decal, claim forms, identification card and a manual which outlines the benefits under this Program and gives complete instructions on how to complete the claim form. We look forward to your wholehearted participation in this Prepaid Prescription Drug Program.

Sincerely,

/s/ Ernest A. Maxwell, M.D.
ERNEST A. MAXWELL, M.D.
Vice President, Medical Director

EAM:jc
Enclosure

LETTER FROM JUDY JOHNSON TO PATTS DRUG STORE, DATED DECEMBER 20, 1974 ("EXHIBIT 7" TO DEPOSITION OF JUDITH M. JOHNSON, NOVEMBER 20, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

BLUE SHIELD OF TEXAS

[LOGO]

Ernest A. Maxwell, M.D.
Vice President, Medical Director

Post Office Box 22001
Dallas, Texas 75222
214/741-8751

December 30, 1974

Patts Drug Store
150 Terrell Plaza
San Antonio, Texas

Gentlemen:

Thank you for your interest in the Prepaid Prescription Drug Program and your request to participate.

You may participate in this program by completing the enclosed Participating Drug Pharmacy Agreements and mailing them to Blue Cross and Blue Shield of Texas, P.O. Box 22001, Dallas, Texas 75222. One executed agreement will be returned to you. In completing this form, be sure that all requested information is given. Each corporate or individual owner of a pharmacy or pharmacies must complete a Participating Agreement in order to participate.

If you want your checks sent to a central billing address, only one set of agreements should be completed. Place

the name of your pharmacy and the billing address in the spaces provided, and on a separate sheet of paper, list the address of each pharmacy with its permit number and the names of the pharmacists employed at each store location. However, if you have several stores and want each store to have its own billing address and number, we will be glad to send as many additional copies of the contract as you need.

When we receive the Participating Agreements, we will send a window decal, claim forms, identification card, and a manual which outlines the benefits under this program and gives complete instructions on how to complete the claim form.

We look forward to your wholehearted participation in the Prepaid Prescription Drug Program. If you have any questions or comments, please feel free to contact us.

Sincerely,

/s/ Judy Johnson
JUDY JOHNSON, Assistant to the
Vice President, Medical Director

JJ:cw

enclosures

I do not choose to participate. Your fee allowed is wholly inadequate and does not take into consideration the different services which each individual pharmacy perform. Furthermore, the setting of [illegible] the pharmacies involved, is both capricious and inconsiderate and I feel entirely unfair to the pharmacist involved.

/s/ Albert Papa
Owner
Patts Drug #2

MEMORANDUM FROM DAVID THIGPEN TO RAY PACE, DATED NOVEMBER 19, 1974 ("EXHIBIT 12" TO DEPOSITION OF JUDITH M. JOHNSON, NOVEMBER 20, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

BLUE CROSS AND BLUE SHIELD OF TEXAS

INTER-OFFICE CORRESPONDENCE

Date: 11-19-74

To: Dallas—Ray Pace

Dept: Director of Alternative Delivery Systems

From: David Thigpen

Dept: San Antonio

Subject: RE: Sommers Drug Stores
Effective Nov. 18

Message:

Sommers Drug Store will be a provider under our Drug Program. They would like for us to issue one provider number with a suffix for each store. All of the stores locations will file their claims with Sommers main office and Sommers main office will bill us and we will make a payment to the Sommers main office.

As you know this account was very important for our Drug Program. Please extend my thanks to Judy Johnson.

DT:lw

To Judy Johnson 11-21-74

MEMORANDUM FROM DAVID THIGPEN TO JUDY JOHNSON, DATED NOVEMBER 19, 1974 ("EXHIBIT 13" TO DEPOSITION OF JUDITH M. JOHNSON, NOVEMBER 20, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

BLUE CROSS AND BLUE SHIELD OF TEXAS

INTER-OFFICE CORRESPONDENCE

Date: 11-19-74

To: Dallas—Judy Johnson

Dept: Medical Department

From: David Thigpen

Dept: San Antonio

Subject: RE: Sommers Drug Store

Message:

This large drug chain has agreed to join our drug program November 18.

Our entire Foundation Program would not have been successful without them and I want to thank you for all of your help in securing this contract.

DT:lw

PARTICIPATING DRUG PHARMACY AGREEMENT BETWEEN GROUP LIFE AND HEALTH INSURANCE COMPANY AND WALGREEN, INC./TEXAS, DATED JANUARY 27, 1970 ("EXHIBIT 19" TO DEPOSITION OF JUDITH M. JOHNSON, NOVEMBER 20, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

PARTICIPATING DRUG PHARMACY AGREEMENT

between

GROUP LIFE & HEALTH INSURANCE COMPANY

(Herein called Blue Shield)

Dallas, Texas

and

WALGREEN INC./TEXAS

(Herein called the Participating Pharmacy)

Retail Drugs
(Type of Organization)

Billing Address: 4300 Peterson Ave., Chicago, Ill. 60646
(Address)

Pharmacy Permit No. ———

1. The Participating Pharmacy agrees that all pharmacists dispensing drugs in its behalf are to be considered participating pharmacists. The pharmacists currently employed by the Participating Pharmacy are:

Participating Drug Pharmacy Agreement (Walgreen)

Name	License No.
See list attached	———
———	———
———	———
———	———
———	———

2. Blue Shield agrees to provide the Participating Pharmacy with a manual which will stipulate the drugs for which benefits are available and drug deductible applicable to each person to whom drugs are to be dispensed under Section 3 of this agreement, and in which identification codes for certain of the drugs for which benefits are provided will be stipulated. Blue Shield agrees to provide the participating pharmacy with claim forms for payment in accordance with Section 3 of this participating agreement. The Participating Pharmacy agrees to complete all information required on the claim form, to retain a copy as a permanent record and to submit the original to Blue Shield.

3. The Participating Pharmacy shall dispense drugs to Subscribers who are covered under prescription drug expense contracts underwritten by Blue Shield, in accordance with the terms of such contracts as described in the Texas Blue Shield Pharmacy Manual at the time of service.

4. The Subscriber will pay to the Participating Pharmacy for each dispensed drug an amount not to exceed the required drug deductible stated in the manual for his group at the time the drug is dispensed. Except for dispensed drugs whose usual and customary charge is less than the drug deductible for the participant's

group as stated in the manual, Blue Shield agrees to pay, for each drug provided under Section 3, above, of this agreement, an amount equal to the total of the acquisition cost for such drug plus a professional dispensing fee of $2.00 less the applicable deductible. Except for dispensed drugs whose usual and customary charge is less than the drug deductible for the participant's group stated in the manual, the Participating Pharmacy agrees to accept as full payment for each drug provided under Section 3, above, of this agreement, an amount equal to the total of the acquisition cost for such drug plus the professional dispensing fee of $2.00.

Acquisition cost shall be the actual invoice cost to the Participating Pharmacy or to the company, organization or its affiliates with which the Participating Pharmacy is associated, whichever is less. Actual invoice cost shall include and reflect, with the exception of cash discounts, all trade and quantity discounts, rebates and price concessions, if any, granted by the supplier, wholesaler, or manufacturer to the Participating Pharmacy or to the company or organization with whom the Participating Pharmacy is associated.

5. The Participating Pharmacy agrees to maintain all business records supporting its acquisition cost of all drugs. The Participating Pharmacy agrees that Blue Shield shall have the right to inspect all claims forms and records necessary to establish compliance with this agreement at any time during regular business hours. The Participating Pharmacy agrees to furnish Blue Shield within fifteen (15) days, after the date of receipt of a written request from Blue Shield, with a copy of the drug purchase invoice showing the acquisition cost to the Participating Pharmacy as hereinabove computed.

6. The Participating Pharmacy shall perform all professional and other services under this agreement as an independent contractor and shall be free to exercise its own judgment on all questions of professional practice. Blue Shield is the underwriter of the insurance protection only. The Participating Pharmacy shall not be liable for any claim, injury, demand or judgment based upon contract, tort or other grounds (including warranty or merchantability) arising out of the sale, compounding, dispensing, manufacturing or use of any prescription drug service dispensed by the Participating Pharmacy pursuant to this agreement.

7. The Participating Pharmacy agrees not to engage in any advertising relative to Blue Shield prescription drug expense contracts without prior approval of Blue Shield.

8. This agreement may be terminated at any time by either party by giving at least fifteen (15) days prior written notice to the other party.

GROUP LIFE & HEALTH
INSURANCE COMPANY

By /s/ Tom L. Beauchamp, Jr.
President

Dated at Dallas, Texas this
27th day of January, 1970.

_____

By /s/ Joel H. Levin,
Title: Asst. Sec'y

Dated at ———, Texas this
—— day of ———, 19—.

Participating Drug Pharmacy Agreement (Walgreen)

Internal Revenue Employer Identification No. 36-1924031

or

If you do not have a Tax No.,
your Social Security No. ————————.

			Pharmacy Permit No.		
Walgreen	Drug	Store	320	2582	1725 Pacific, Dallas 75201
"	"	"	281	2583	175 Camino So. Sh. Ctr., Houston
"	"	"	454	2584	9520 Homestead, Houston 77016
"	"	"	462	2587	203 Sharpstown Ctr., Houston 77036
"	"	"	458	2585	8540 Long Point Rd., Houston 77055
"	"	"	471	9554	3200 Main, Houston 77002
"	"	"	475	2586	13345 North Shore Dr., Houston 77015
"	"	"	481	2588	2946 S. Shepherd, Houston 77006
"	"	"	794	17543	945 E. Shaw, Pasadena 77502
"	"	"	815	2591	435 Proctor St., Port Arthur 77640
"	"	"	877	2592	3638 Fredericksburg Dr., San Antonio 78201
"	"	"	878	2594	616 S.W. Military Dr., San Antonio 78221
"	"	"	881	2595	260 Mall N. Star Sh. Ctr., San Antonio 78216
"	"	"	883	2593	139 Walgreen Plaza, San Antonio 78237

MEMORANDUM ENTITLED "SPECIAL PLAN MEETINGS: AUTO PRESCRIPTION DRUG PROGRAM" ("EXHIBIT 23" TO DEPOSITION OF JUDITH M. JOHNSON, NOVEMBER 20, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

———

SPECIAL PLAN MEETINGS

AUTO PRESCRIPTION DRUG PROGRAM

WASHINGTON, D.C.
April 22, 1969

ATLANTA, GEORGIA
April 24, 1969

SAN FRANCISCO, CALIFORNIA
April 29, 1969

CHICAGO, ILLINOIS
May 1, 1969

INTRODUCTION

The 1967 Auto Health Care Settlement provides for implementation of a *service* benefit prescription drug program with *participating* pharmacies effective October 1, 1969. In order for Plans to be eligible for participation, complete conformance with the specifications is required. The primary purpose of this series of meetings is to:

1. Review and explain the drug program specifications.
2. Review Participating Plan requirements and discuss solutions to specific Local Plan problems.
3. Discuss administrative details.

Memorandum—Auto Prescription Drug Program

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Master Group Operating Agreements—Addendum No. 1

Administrative Items .....

Participating Provider Campaigns
Identification Cards
Claims Processing Guidelines
Descriptive Literature
Coordination of Benefits

RATING AND DATA REQUIREMENTS—SEMINAR

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Data Requirements
Rating Guidelines
Ford Equalization Procedures

General Motors Salaried .....

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Plans in Attendance
Note Paper

Memorandum—Auto Prescription Drug Program

MEETING AGENDA

8:30	Registration
9:00	Introduction and Orientation
9:30	Workshop Seminars (coffee and rolls will be served)
11:00	Workshop Seminars
12:30	Lunch
2:00	Workshop Seminars
3:30	Summary and Closing Remarks
4:00	Adjournment

Workshop Seminars

Three distinct Workshop Seminars will be held during each time period. They are:

—Benefit Specifications

—Administrative Details and Operational Procedures

—Rating and Data Requirements

Assignment to each Workshop Seminar session will be made by the number on each attendee's name tag. By rotating at each time period, everyone will have the opportunity to participate in all of the Workshop Seminars.

AUTO PRESCRIPTION DRUG PROGRAM

National Implementation Timetable of Critical Tasks

Task	Completion Date
1. Complete Administrative Manual Section 4 and distribute to Participating Plans.	5/1/69
2. Approval and signing of the Master Group Operating Addendum on Drugs.	5/1/69
3. Determine Drug Program Statistical Data Requirements and communicate same to Participating Plans.	5/1/69

Task	Completion Date
4. Hold Regional Drug Meetings to explain details of the drug specifications and provide operational guidelines.	5/1/69
5. Follow up with Plans to ensure that certificate filings have been made.	6/1/69
6. Signing of Participating Plan Agreement Addendum on Drugs.	6/1/69
7. Report to Management and Union of each Auto Account the status of written agreements with the individual Plans, and alternate arrangements which may be necessary to achieve the level of benefits specified by the National Account Program.	7/1/69
8. Secure Participating Plan rates for the Drug Program. (Not applicable to Ford Motor Company.)	7/1/69
9. Develop employee literature for distribution nationally.	7/15/69
10. Obtain results of each Plans' Participating Pharmacy campaigns. (It is estimated these campaigns will run for a six (6) week period.)	8/1/69
11. Follow-up with Plans to determine the readiness of their claims handling system.	8/1/69
12. If necessary, issuance of identification cards reflecting drug coverage.	9/1/69
13. Distribution of employee literature.	9/1/69
14. Effective date of the Service Benefit Prescription Drug Program.	10/1/69

Draft: 4-15-69

AUTO NATIONAL ACCOUNT PROGAM ADMINISTRATIVE MANUAL

PART 4

SERVICE BENEFIT PRESCRIPTION DRUG PROGRAM

I. DEFINITIONS

A. *Local Plan*

Any Blue Cross and/or Blue Shield Plan through which a member is enrolled for a Service Benefit Prescription Drug Program as a part of the Auto National Account Program.

B. *Local Plan Area*

The geographic area in which a Local Plan ordinarily offers coverage.

C. *Physician*

One who is legally qualified and licensed to practice medicine and perform surgery at the time and place services are rendered (as indicated in Part 3 of this Manual); and for the purpose of this program a doctor of medicine, a doctor of osteopathy or a Podiatrist who is legally licensed to prescribe medications within the scope of that license.

D. *Dentist*

A doctor of dental surgery or a doctor of dental medicine legally licensed to prescribe medications within the scope of that license.

E. *Prescription Legend Drug*

Any medicinal substance—the label of which, under the Federal Food, Drug, and Cosmetic Act is required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription."

F. *Pharmacist*

A person licensed to dispense Prescription Legend Drugs under the laws of the State wherein he practices.

G. *Pharmacy*

A licensed establishment where Prescription Legend Drugs are dispensed by a Pharmacist.

H. *Provider*

A Pharmacy, Pharmacist, Physician, Dentist or any other person or organization legally licensed to dispense drugs.

I. *Prescription Order*

A written or oral request by a Physician or Dentist for a single Prescription Legend Drug.

J. *Covered Drug*

Any Prescription Legend Drug or any medication compounded by the Provider which contains a Prescription Legend Drug (except contraceptive medications) when ordered by a Physician or a Dentist for which a written Prescription Order is customarily prepared, a separate charge of $2.00 or more is customarily made and which is not entirely consumed at the time and place of the Prescription Order, and injectable insulin.

Compounded medications which contain a Prescription Legend Drug are not required to bear the legend "Caution: Federal Law prohibits dispensing without a prescription." However, when a Provider prepares, pursuant to a Prescription Order, a compounded medication in which at least one ingredient is a Prescription Legend Drug, the compounded medication is a Covered Drug if it meets the other requirements in the definition.

Any drug for which the Provider customarily charges less than $2.00 is *not* a Covered Drug under the program. Injectable insulin is not a Prescription Legend Drug and does not require a Prescription Order.

K. *Co-Payment Amount*

Any amount not to exceed $2.00 to be paid by a member for each separate Prescription Order and refill of a Covered Drug.

A member will not be required to pay a Co-Payment Amount of more than $2.00 for any Covered Drug but could be charged a lesser amount by the Provider. In all cases a Co-Payment Amount of $2.00 will be used by a Local Plan in determining the benefit payment regardless of the amount actually paid by a member.

L. *Participating Contract*

The agreement entered into between a Local Plan and a Participating Provider which sets forth their respective rights and obligations.

M. *Participating Provider*

A Provider who has entered into a Participating Contract with a Local Plan to provide a Covered Drug at a cost to a member not to exceed the Co-Payment Amount of $2.00.

N. *Non-Participating Provider*

A Provider who has not entered into a Participating Contract with a Local Plan.

O. *Acquisition Cost*

The actual invoice cost of a Drug (with the exception of cash discounts, but including trade discounts) to the Provider or to the company, organization or its affiliates with which the Provider is associated, whichever is less.

This definition recognizes that the actual cost of a drug to certain large chain stores, hospitals, etc. is often less than the cost to other Providers. Consequently, the cost of the drug to the company or organization will be used rather than the cost to the establishment or individual actually dispensing the drug.

Cash discounts allow a reduction from invoice price for prompt payment. For example, 2/10 net 30 permits the invoice to be reduced by 2 percent if payment is made within 10 days. Cash discounts are *not* considered in determining the actual invoice cost.

Trade discounts allow reductions from invoice price without regard to date of payment. Discounts given for quantities purchased, or

for items purchased at a time other than when they are in high demand are examples of trade discounts. Trade discounts are considered in determining the actual invoice cost.

P. *Dispensing Fee*

An amount predetermined by a Local Plan to compensate a Provider for dispensing a Covered Drug.

Q. *Usual and Customary Charges*

The amount charged by: 1) a Participating Provider for injectable insulin; 2) a Non-Participating Provider for a Covered Drug; or 3) a Provider out of a Local Plan Area for a Covered Drug; not to exceed the maximum allowable amount as determined by a Local Plan.

R. *Prescription Charges*

For a Participating Provider, the Acquisition Cost plus the Dispensing Fee for a Covered Drug except for injectable insulin. In the case of injectable insulin the Usual and Customary Charge or the Acquisition Cost plus the Dispensing Fee, whichever is lower. For a Non-Participating Provider, the Usual and Customary Charge for a Covered Drug. For a Provider out of a Local Plan Area, the Usual and Customary Charge for a Covered Drug.

II. BENEFIT AND LIMITATIONS

Subject to the Exclusions in Section III, benefits shall be provided for Covered Drugs dispensed on and after

the effective date of the Program. It is the intent of this Program that the benefits shall be uniform for all members except in those instances where such might be contrary to the laws of the State in which the prescription is dispensed.

A. *Payment—In a Local Plan Area*

1. Participating Provider: A Local Plan will pay to a Participating Provider the Prescription Charges for each Covered Drug less the Co-Payment Amount of $2.00.

   Examples: (Other than the Co-Payment, all amounts are hypothetical)

Participating Provider
Prescription Legend Drug

Acquisition Cost	$7.50
Dispensing Fee	+1.75
Prescription Charges	$9.25
Less Co-Payment	−2.00
Payment to Provider	$7.25

Participating Provider
Injectable Insulin
(4 Vials of U-40 Insulin)

#1		#2	
Acquisition Cost	$4.00	Usual & Customary	$5.00
Dispensing Fee	+1.90		
Prescription Charges	$5.90	Prescription Charges	$5.00
Less Co-Payment	−2.00	Less Co-Payment	−2.00
Payment to Provider	$3.90	Payment to Provider	$3.00

In the example on injectable insulin, a Local Plan will pay a Participating Provider according to # 2 because the Usual and Customary Charge method results in a lower

Prescription Charge than does the Acquisition Cost plus the Dispensing Fee method.

2. Non-Participating Provider: A Local Plan will pay to a member 75% of the remainder of the Prescription Charges of a Non-Participating Provider for each Covered Drug after deducting the Co-Payment Amount of $2.00.

   Example: (Other than the Co-Payment, all amounts are hypothetical)

Non-Participating Provider

Usual & Customary Charge	$6.40
Less Co-Payment	−2.00
	$4.40
Percent of Remainder	× .75
Benefit Payment	$3.30

B. *Payment—Out of a Local Plan Area*

When services are received out of a Local Plan Area payment to the member will be 100% of the remainder of the Prescription Charges for each Covered Drug after deducting the Co-Payment Amount of $2.00.

Provider Out of a Local Plan Area

Usual & Customary Charge	$6.40
Less Co-Payment	−2.00
	$4.40
Percent of Remainder	×1.00
Benefit Payment	$4.40

III. BENEFIT EXCLUSIONS

A. Drugs for which a Provider customarily charges less than $2.00.

Memorandum—Auto Prescription Drug Program

B. Drugs dispensed prior to the effective date of this Program.

C. Any charge for non-legend drugs and medications other than injectable insulin.

D. Any charge for administration of Prescription Legend Drugs and injectable insulin.

E. Any charge for a contraceptive medication regardless of its intended use.

F. Any charge for devices or appliances (hypodermic needles, syringes, support garments and other non-medicinal substances) regardless of their intended use.

G. Services for which benefits are applicable under Workmen's Compensation Laws according to the provisions of the Workmen's Compensation portion, Part 5 of this manual.

H. In the event of any payment for services under this program, the Plan shall be subrogated to all the Member's rights of recovery therefor against any person or organization except against insurers on policies of insurance issued to and in the name of the Subscriber, and the Member shall execute and deliver such instruments and papers and do whatever else is necessary to secure such rights according to the Provisions of the subrogation portion, Part 5 of this Manual.

I. Services to the extent they are payable under Title XVIII of the Social Security Amendments of 1965 (Public Law 89-97, 89th Congress, First Session, as amended).

Memorandum—Auto Prescription Drug Program

J. Services to the extent they are payable under any health care program supported in whole or in part by funds of the Federal Government or any state or political subdivision thereof are excluded as benefits except Title XIX Social Security Amendments of 1965 (Public Law 89-97, 89th Congress, First Session, as amended).

K. The charge for medications furnished on an in-patient or out-patient basis covered under any Blue Cross and/or Blue Shield contract, or another carrier providing group coverage for Prescription Legend Drugs or injectable insulin through a Coordination of Benefits provision.

L. The charge for more than a 34-day supply of medication, except that the Plan will cover 100 unit doses (tablet, capsule, etc.), of a natural thyroid product and 100 unit doses of nitroglycerine.

M. The charge for any prescription refill in excess of the number specified by the physician or any refill dispensed after one year from the physician's order.

Draft: 4-15-69

INFORMATION PERTAINING TO PART 4 of the ADMINISTRATIVE MANUAL

These guidelines developed for use by Participating Plans in administering the Service Benefit Prescription Drug Program, when finalized, will be included in Part 4 of the Administrative Manual, H.S.M.D., Auto National Account Program. The guidelines interpret and explain the benefits set forth in the specifications for the program and describe the regulations governing benefit payment. The purpose of this paper is to provide additional information about some of the interpretations, explanations and descriptions that are contained in the administrative guidelines.

1. *Acquisition Cost*

   Cash discounts will not be considered in determining the actual invoice cost of a drug. Cash discounts allow a reduction from invoice price for prompt payment. Cash discounts, when offered, are taken solely at the option of the Provider and the supply and intended use of his capital will be the primary factor influencing the taking of such discounts. A Provider may or may not choose to take advantage of a cash discount on any given invoice dependent upon his degree of liquidity. Some Providers, as a matter of practice, may never take cash discounts because similar or greater savings can be realized through other uses of their capital. To consider cash discounts in determining acquisition cost would, in effect, impose a penalty on the Provider who takes such discounts and could force an unnecessary change in his business practice.

Trade discounts will be considered in determining the actual invoice cost of a drug. Trade discounts allow reductions from invoice price without regard to date of payment. Discounts given for quantities purchased, or for items purchased at a time other than when they are in high demand are examples of trade discounts. As a rule, trade discounts are considerably greater than the usual 2 per cent discount offered for prompt payment.

A trade discount may or may not be specifically identified on an invoice but the invoice price will be affected by the discount. For example, a Provider might normally pay $10.00 for 100 units of drug "X", but be given a 10 per cent discount if he buys 500 units or more. If he makes such a quantity purchase he may receive an invoice which shows:

500 units of drug "X" @ $10.00/100 units =	$50.00
less discount of 10% =	5.00
Invoice Price =	$45.00

or he may receive an invoice which simply shows:

500 units of drug "X" @ $9.00/100 units = $45.00

In each case the invoice price is the same even though the trade discount is not specifically identified in the second instance.

Providers sometimes receive discounts in the form of cash rebates from a supplier based on the dollar volume purchased during a given period of time. While such "discounts" are not reflected in invoice prices they can be revealed through the knowledge and judgment applied during the auditing process. To the degree possible such rebates will be considered in the determination of acquisition cost.

2. *Covered Drug*

A compounded medication is a final dosage form produced by a Provider through combining or uniting two or more ingredients. When ordered by a Physician or a Dentist, and subject to the other pertinent requirements, any medication compounded by a Provider which contains a Prescription Legend Drug is a Covered Drug even though compounded medications are not required to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription." A final dosage form produced by the simple act of dilution is not considered to be a compounded medication.

Injectable insulin is not a Prescription Legend Drug and does not require a Prescription Order.

A written, signed prescription order is not required for other than Class A narcotics. However, if a Prescription Order is transmitted in other than a written form, pharmacy laws require the Provider to immediately reduce the transmission to writing which has the effect of making all Prescription Orders written orders. The phrase ". . . for which written Prescription Order is customarily prepared . . ." is included in the administrative guidelines to preclude changes in patterns of care. Physicians frequently administer drugs in connection with medical care rendered in the home or office as do Dentists in relation to dental care. Such drugs are not dispensed by a Provider on the basis of a written Prescription Order being customarily prepared, and it is not the intent of the program to qualify them as a Covered Drug.

The phrase " . . . and which is not entirely consumed at the time and place of the Prescription Order,

. . ." is used in the administrative guidelines along with other parts of the definition of a Covered Drug to further support the same purpose for which ". . . a written Prescription Order is customarily prepared . . ." is used. The per dose cost of immunizations, antibiotics, diagnostics, allergens, etc., which Physicians frequently administer as a part of home or office medical care, is negligible. The greatest portion of the charge, if any, is for administration of the drug. To provide coverage for drugs which are entirely consumed at the time and place of the Prescription Order could create undesirable and inflationary patterns of care.

Any drug for which the Provider customarily charges less than $2.00 is not a Covered Drug. The Service Benefit Drug Program which is a part of the Auto National Account Program specifies members share in the cost of benefits by paying a Co-Payment Amount of $2.00 (This Co-Payment Amount is significantly greater than that recommended by Blue Shield-Blue Cross.) Recent studies show that prescription charges for slightly more than 15 per cent of the drugs dispensed in Michigan are less than $2.00. It is not the intent of the program that the members' Co-Payment obligation result in their paying more for drugs than they normally would have paid if they were not enrolled in the program. Since this possibility exists due to the $2.00 Co-Payment Amount of the program, drugs for which the Provider customarily charges less than $2.00 will be the responsibility of the member and not a liability of the program.

3. *Dispensing Fee*

Local Plans will establish and use pre-determined Dispensing Fee amounts in making benefit pay-

ments to Participating Providers. The Dispensing Fee is designed to compensate the Participating Provider for professional services and the other costs of doing business (e.g. rent, utilities, equipment, storage, packaging materials, sales tax, etc.). Local Plans may use a uniform Dispensing Fee for all Participating Providers in their Plan area or may vary the Dispensing Fee according to a categorization of Providers.

Initially, a uniform Dispensing Fee will have the characteristic of rewarding those Providers who operate more efficiently. And, in an overall sense, a uniform Dispensing Fee is reasonably equitable to all Providers. While there are variances in the elements that compromise the operating costs of Providers, there is also a certain equalizing effect when the consideration is return on investment.

The difference in pharmacists salaries, which constitutes a major portion of a Provider's overhead, can be used to illustrate the point. In metropolitan areas salaries are higher than those paid in outlying regions, but this difference in the cost of doing business is offset through the larger volume of business generated in metropolitan areas due to the greater concentration of population and Physicians. The cost of doing business is also affected by the range of services offered by the Provider. However, the independent Pharmacy which provides such services as home delivery, maintaining patient medication profiles and staying open 24 hours a day does not generally incur other costs such as warehousing which affect the large volume, chain store Provider.

Ultimately it appears there may be a need for refinement in the uniform Dispensing Fee method

of reimbursement in consideration of differences in the Providers' location and range of services offered, and in recognition of the desirability of incentives to encourage more efficient operations. At the present time, however, there is no meaningful way to measure the value of such differences or determine the affect of any incentive system. These issues will be continuously studied, and perhaps pilot incentive programs can be used, to arrive at the most effective method of Provider reimbursement.

4. *Prescription Legend Drug*

The word "State" is not included in the definition of a Prescription Legend Drug in order to ensure the greatest possible degree of uniformity in the benefits of the program. State laws may require a prescription for some drugs even though such drugs are not required to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription." Such state laws are particularly applicable to narcotic agents which may be subject to abuse. For example, paregoric may not be dispensed in Michigan without a prescription, but it may be in most other areas. On the other hand, the F.D.A. has not recognized some drugs as having any therapeutic value, and will not permit them to be used outside the State in which they were developed. In Ohio, such a drug (purported to be a cancer cure) is available when dispensed with a prescription, but it cannot be purchased elsewhere. To include drugs which are subject to State, but not Federal, law as Covered Drugs would be discriminatory against some members enrolled in the program.

CERTIFICATE
DRAFT
April 14, 1969

(PLAN)

PRESCRIPTION DRUG GROUP BENEFIT PROGRAM

This Certificate, upon payment of the additional subscription rate, supplements the Certificates of (Plan) by adding prescription drug benefits hereunder. However, this Certificate is subject to all the terms and conditions of the (Plan) which this Certificate supplements, except as herein expressly otherwise provided.

In witness whereof (Plan) by their duly authorized agents have executed this Certificate.

Section I—ELIGIBILITY

Members eligible for benefits hereunder are those members eligible for benefits under the (Plan) Certificates which this Certificate supplements, subject to the following exceptions and limitations:

A. Persons covered under any "sponsored dependent" rider to the (Plan) Certificates are ineligible for benefits under this Certificate.

B. Retirees and their dependents and surviving spouses of employees, whether active or retired at date of death, and their dependents are ineligible for benefits under this Certificate.

Section II—DEFINITIONS

In addition to other definitions set forth in the (Plan) Certificates which this Certificate supplements and for the purpose of this Certificate only, the following terms shall have the following meanings:

A. "Covered Drugs" means any Prescription Legend Drug or injectable insulin when ordered by a Physician for which a written Prescription Order is customarily prepared, a separate charge of $2.00 or more is customarily made and which is not entirely consumed at the time and place of the Prescription Order, except as herein limited or excluded.

Compounded medications which contain a Prescription Legend Drug are not required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription". However, when a Provider prepares, pursuant to a Prescription Order, a compounded medication in which at least one ingredient is a Prescription Legend Drug, the compounded medication is a Covered Drug if it meets the other requirements in the definition. Injectable insulin is not a Prescription Legend Drug and does not require a Prescription Order.

B. "Member's Liability" means the amount of $2.00 to be paid by the member of each separate Prescription Order and refill for Covered Drugs toward the cost of each Covered Drug and each refill of a Covered Drug.

C. "Participating Provider" means a Provider who has entered into a participating contract with (Plan) to provide benefits under this Certificate.

D. "Non-participating Provider" means a Provider who has not entered into a participating contract with (Plan) .

E. "Pharmacy" means a licensed establishment where prescription drugs are dispensed by a pharmacist licensed under the laws of the State wherein the pharmacist practices.

F. "Prescription Legend Drug" means any medicinal substance—the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription".

G. "Prescription Order" is the request for medication by a Physician as defined in the (Plan) Certificate.

H. "Provider" means any Pharmacy, Physician, or any other person or organization legally licensed to dispense drugs.

Section III—BENEFITS PROVIDED

A. The Participating Provider will furnish Covered Drugs and will not make any charge or collect from the member any amount which exceeds the Member's Liability amount for Covered Drugs.

B. The member, upon submission of proof of payment acceptable to (Plan) shall be entitled to reimbursement from (Plan) for Covered Drugs obtained from a Non-participating Provider in an amount equal to 75% of the usual and customary charges as determined by (Plan) after the Member's Liability amount has been satisfied. For Covered Drugs obtained from a Provider located outside the (Plan) area, the member upon submission of proof of payment acceptable to (Plan) , shall be entitled to 100% of usual and customary charges or the

actual charges if less for Covered Drugs, as determined by (Plan) , less the Member's Liability amount.

Section IV—EXCLUSIONS

In addition to the exceptions, exclusions and limitations of the (Plan) Certificates, and Riders thereto, no benefits shall be payable hereunder for the following:

A. Any drug for which the Provider customarily charges less than $2.00.

B. Any charge for a contraceptive medication, even if such medication is a Prescription Legend Drug, and any charge for therapeutic devices or appliances (including but not by way of limitation, hypodermic needles, syringes, support garments, and other non-medical substances) regardless of their intended use.

C. Any charge for administration of a Prescription Legend Drug or injectable insulin.

D. The charge under any one prescription order for more than a 34 consecutive day supply of a medication, except that (Plan) will cover 100 unit doses (tablet, capsule, etc.) of a natural thyroid product and 100 unit doses of nitroglycerine.

E. The charge for any prescription refill in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's Order.

F. Covered Drugs for which no charge is customarily made to the member.

G. Covered Drugs dispensed to a member when benefits for Covered Drugs are provided under the (Plan) Certificates and Riders thereto.

H. Notwithstanding the provisions of any applicable Coordination of Benefits Program in effect as a rider to the (Plan) Certificate, benefits for Covered Drugs shall be provided, subject to the final determination of (Plan's) liability, whether primary-secondary. In no case will (Plan) make payment of an amount which when added to the amount paid by another Plan, exceed that which is provided by this Prescription Drug Group Benefit Program.

Section V—SUBSCRIPTION RATES

The Subscriber agrees to pay (Plan) monthly in advance unless otherwise provided, the applicable subscription rate for the coverage of this Certificate. The applicable rate payable at the time of issuance of this Certificate is indicated upon the Rate Schedule delivered to the Subscriber or his remitting agent contemporaneously herewith which is part hereof and receipt of which is acknowledged. The applicable rate is subject to adjustment from time to time according to the (Plan) merit rating program, and wherever applicable, the merit rating formula by the giving of thirty (30) days written notice to the Subscriber or his remitting agent. The Subscriber by acceptance hereof agrees that notice to the remitting agent of the amount of any such adjustments applicable to the group will be notice to the Subscriber of the amount applicable to him.

Section VI—GENERAL

A. In the event the subscriber shall become a Group Conversion subscriber, this (Plan) Prescription Group Drug Benefit Certificate shall be terminated without action on the part of (Plan) .

B. As a condition precedent to the approval of claims hereunder, or for any other reason, each member authorizes and directs any Provider who furnished benefits hereunder to make available to (Plan) information relating to all Prescription Orders, copies thereof and other records as needed by (Plan) .

C. The benefits under this Certificate shall be provided in the form of Service, and payment therefor by (Plan) shall constitute a complete discharge of the obligation of (Plan) to the extent of the service rendered in accordance with the terms and conditions of this Certificate. (Plan) does not undertake to supply a provider for the member.

D. (Plan) shall not be liable for any claim or demand for injury or damage arising out of in connection with the manufacturing, compounding, dispensing, or use of any Legend Drug whether or not covered under this Certificate.

E. (Plan) reserves the right to deny benefits for any drug prescribed or dispensed in a manner contrary to accepted medical or pharmaceutical practice.

AUDITING AND CONTROL

In Michigan, approximately 125 on-site audits of Providers will be performed each month by the equivalent of three full time field auditors. A minimum of 25 randomly selected prescriptions, from among those submitted during the most recent six month benefit payment period, will be audited for each Provider. Among the check list items to be audited are acquisition costs which will be verified by visual inspection of bottle sizes, purchase invoices and wholesaler or manufacturer billing statements. In addition, the actual prescription will also be audited to ascertain such facts as: the prescribed drug was dispensed in the quantity specified; the number of refill orders; and the prescription was issued to a person eligible for and enrolled under the Drug Program.

The Control Plan will assume responsibility for having audits conducted of chain store pharmacies operating in more than one Local Plan Area, and the results of these audits will be given to all involved Plans. The sole purpose of these audits will be to verify the actual acquisition cost only. Local Plans will be responsible for performing audits of individual Providers located in their area in relation to all other items of interest exclusive of acquisition cost.

Following is the outline used by Michigan Service Review Analysts in conducting Provider Audits.

MICHIGAN

ORIGINAL AUDIT

PRESCRIPTION DRUG PROGRAM

1. An advance letter must be sent seven to ten days prior to date of audit. A phone call may be substituted at the Service Analyst's discretion.
2. Deal with the owner, manager, or pharmacist in charge (not with just a clerk or a bookkeeper).
3. Introduce yourself as representing Blue Shield (show calling card) and refer to prior letter (copy in case file).
4. Check licensure:
   - A. Michigan State Pharmacy License for the facility.
   - B. State Registration number for pharmacist-on-duty.
5. Give manager a list of claims to be audited (in prescription number order). Request access to any and all records necessary to verify that the pharmacy has complied with all regulations. Sources include, but are not limited to:
   - A. Original copy of prescription or order (need not be signed by a physician).
   - B. Financial ledger (daily log book, etc.). Charge data frequently appears on prescription itself.
   - C. Invoices.
   - D. Pharmacy carbon copies of claims submitted.

6. Perform comparison audit (claims vs records):

   A. Patient, sex, relationship, age, etc.

      1. A Unifile (D1) transcript will be provided. The analyst must verify that the recipient of the drug (per the pharmacy prescription copy) is eligible for drug benefits.

      2. In the claims cycle, all eligibility verification will be done on a contract basis only.

   B. Prescription number and date.

   C. See copy of prescription. Need not be signed by a physician.

   D. Thirty-four day supply limit (with exception of natural thyroid products and nitroglycerine which may be dispensed in units of 100).

   E. Drug and quantity prescribed same as drug and quantity dispensed.

   F. Acquisition cost determination:

      1. A container should be seen for each drug claimed and the cost and size (50, 100, 500, etc.) noted. Cost data frequently appears on a container in stock.

      2. At least four invoices should be seen.

   G. Usual and customary charge should be determined for each claim checked to ascertain that the Provider customarily charges $2.00 or more for the items being checked. This can be done in several ways:

      1. Review prescription charges for a similar quantity of the same drug.

      2. Ask the pharmacist for "proof" of his usual fee schedule (a chart, something in writing, etc.) and have him price the drug step by step following his fee schedule.

      3. Review prescription charges (selected at random from store files) to verify a "fee schedule".

   H. The subscriber must never be charged more than $2.00.

   I. *At least four physicians* should be contacted to verify a prescription.

      1. Inform the pharmacist that such a contact will be made as part of routine procedure.

   J. It is not necessary to routinely interview a subscriber. However, certain circumstances may arise which could dictate such an interview (doctor denies writing prescription, name on prescription not an eligible recipient, doctor not contacted, etc.).

7. Disposition of Unfounded case:

   A. Fill out "Case Status Report" with appropriate disposition.

   B. No closing memo need be written.

   C. Indicate in Part II, A, number of claims reviewed.

8. Disposition of Founded case:

   A. Close as "Founded, major problem" under the following circumstances:

      1. Economic discrepancies of *any* amount are noted in *any* of the eighteen claims which are the result of "pharmacy routine".

2. "Pharmacy routine" may be determined in the following manners:

   a. Question the pharmacist: (e.g., Is this five cent acquisition cost overcharge due to mathematical error or is it due to rounding, container fee, etc. figured in most claims?)

   b. Review the pharmacy carbon copies of paid or unpaid claims.

   c. Review more invoices.

3. Drug benefits are provided to an ineligible recipient.

B. Close as "Founded, minor problem" under the following circumstances:

1. Economic discrepancies noted are *not* due to "pharmacy routine" but rather to "occasional human error".

2. Non-economic regulation violations are noted.

9. Resolution of Founded cases:

A. "Founded major problem"

1. Economic discrepancies—order refund audit.

2. Ineligible recipient:

   a. Determine relationship of subscriber to recipient.

   b. Profile contract number involved.

   c. Audit each drug claim paid to contract number involved.

   d. Refer case with all above data to Field Supervisor.

B. "Founded, minor problem": send appropriate letter and/or verbally notify pharmacy of discrepancies.

MICHIGAN

REFUND AUDIT

PRESCRIPTION DRUG PROGRAM

1. Notify pharmacy a refund audit will be done.
   a. Inform pharmacy that more time will be required than an original audit.
   b. Request a specific appointment time, preferably when the pharmacist will be free to work exclusively with the Service Analyst.
2. Claims to be selected (primarily an internal consideration):
   a. Amount of claims audited will depend on dollar volume paid to store:

Dollar Volume	(number of claims *not* including those in original audit)
0-3,000	25
4,000-6,000	75
7,000-10,000	100
10,000 +	200

   b. Select claims from 2-3 different months (the recommendations, in the closing of the original audit, should contain the exact number of claims and months to be included in the work-up).
3. Depending on the Service Analyst's knowledge of the case, only the specific problem noted in the original audit need be audited:
   a. If the refund audit is to determine Total Cost overcharge, there is no need to see each and every prescription, invoice, etc. However, "usual charge" data should be seen.

   b. If the refund audit is to determine Acquisition Cost overcharge and the Service Analyst is *certain* that costs on the bottle are accurate, there is no need to see each and every invoice.
   c. If the problem audited is not directly related to the actual prescription on file, there is no need to review each and every prescription.
   d. However, an occasional claim should be audited for all possible regulation violations.
4. Refund computation:
   a. Determine the "amount paid" to the pharmacy for the audit sample.
   b. Determine the "amount that should have been paid" per the audit.
   c. Determine the "percentage of error" by dividing the difference between a and b by a.
   d. Multiply the total paid to the pharmacy by c.
5. Inform the pharmacy of the results.
6. If the *pharmacy requests* the presence of a representative from the State Pharmaceutical Association during any or all phases of the audit procedure, inform the Field Supervisor and the Association will be contacted. After this initial contact, the Service Analyst will be responsible for dealing with the Association and the pharmacy.
7. In the event that the Association disagrees with our findings, or if the meeting between the three parties results in no refund, refer the case to the Field Supervisor.

8. A store audited for refund should be re-audited in 90 days.

9. If, during the course of the audit, the Service Analyst is certain that the problem originally noted is actually not "major" in scope, he may chose to terminate the review.

   a. Close the refund audit as unfounded.
   Write a closing memo.

   b. Do *not* change the status of the original audit.
   Include a copy of the refund audit closing memo.

NATIONAL ACCOUNT PROGRAM

PARTICIPATING PLAN AGREEMENT

AMENDMENT A

CHRYSLER CORPORATION

The National Account Program Participating Plan Agreement, notwithstanding what is contained to the contrary in Article I, is hereby Amended by addition of the following:

The Participating Plan hereby agrees to underwrite and service the Prescription Drug Program effective October 1, 1969, as set forth in Addendum No. 1 to the Master Group Operating Agreement. A copy of Addendum No. 1 to the Master Group Operating Agreement and Addendum No. 1 to Exhibit "A" is attached hereto and by reference made a part of this Amendment.

This Amendment to the Participating Plan Agreement shall be effective at 12:01 a.m., October 1, 1969, and shall continue in force and effect in accordance with the terms and conditions of the Participating Plan Agreement.

_____ (Plan)	Michigan Hospital Service
_____ (Name)	_____ (Name)
_____ (Title)	_____ (Title)
_____ (Plan)	Michigan Medical Service
_____ (Name)	_____ (Name)
_____ (Title)	_____ (Title)

Memorandum—Auto Prescription Drug Program

NATIONAL ACCOUNT PROGRAM

PARTICIPATING PLAN AGREEMENT

AMENDMENT A

FORD MOTOR COMPANY

The National Account Program Participating Plan Agreement, notwithstanding what is contained to the contrary in Article I, is hereby Amended by addition of the following:

The Participating Plan hereby agrees to underwrite and service the Prescription Drug Program effective October 1, 1969, as set forth in Addendum No. 1 to the Master Group Operating Agreement. A copy of Addendum No. 1 to the Master Group Operating Agreement and Addendum No. 1 to Exhibit "A" is attached hereto and by reference made a part of this Amendment.

This Amendment to the Participating Plan Agreement shall be effective at 12:01 a.m., October 1, 1969, and shall continue in force and effect in accordance with the terms and conditions of the Participating Plan Agreement.

_____	Michigan Hospital Service
(Plan)	
_____	_____
(Name)	(Name)
_____	_____
(Title)	(Title)
_____	Michigan Medical Service
(Plan)	
_____	_____
(Name)	(Name)
_____	_____
(Title)	(Title)

Memorandum—Auto Prescription Drug Program

NATIONAL ACCOUNT PROGRAM

PARTICIPATING PLAN AGREEMENT

AMENDMENT A

GENERAL MOTORS CORPORATION

The National Account Program Participating Plan Agreement, notwithstanding what is contained to the contrary in Article I, is hereby Amended by addition of the following:

The Participating Plan hereby agrees to underwrite and service the Prescription Drug Program effective October 1, 1969, as set forth in Addendum No. 1 to the Master Group Operating Agreement. A copy of Addendum No. 1 to the Master Group Operating Agreement and Addendum No. 1 to Exhibit "A" is attached hereto and by reference made a part of this Amendment.

This Amendment to the Participating Plan Agreement shall be effective at 12:01 a.m., October 1, 1969, and shall continue in force and effect in accordance with the terms and conditions of the Participating Plan Agreement.

_____	Michigan Hospital Service
(Plan)	
_____	_____
(Name)	(Name)
_____	_____
(Title)	(Title)
_____	Michigan Medical Service
(Plan)	
_____	_____
(Name)	(Name)
_____	_____
(Title)	(Title)

Memorandum—Auto Prescription Drug Program

NATIONAL ACCOUNT PROGRAM

MASTER GROUP OPERATING AGREEMENT

ADDENDUM NO. 1

CHRYSLER CORPORATION

This Addendum dated ————————, 1969, is between CHRYSLER CORPORATION (hereinafter referred to as the "Employer") and MICHIGAN HOSPITAL SERVICE, a Michigan nonprofit corporation existing and operating under the provisions of Act 109 P.A. Michigan 1939, as amended, (hereinafter referred to as "Hospital Service") and MICHIGAN MEDICAL SERVICE, a Michigan nonprofit corporation organized and existing under the provisions of Act 108 P.A. Michigan 1939, as amended (hereinafter referred to as "Medical Service").

Hospital Service and Medical Service agree to furnish or cause to be furnished for Enrollees (except persons covered as sponsored dependents, retirees and their dependents, and surviving spouses of employees, whether active or retired at date of death, and their dependents) the benefits under the Prescription Drug Group Benefit Program Certificate, form 87 (50-535).

The Blue Cross and Blue Shield Plan areas where prescription drug coverage is to be provided are set forth in Addendum No. 1 to Exhibit "A", which is attached and by reference made a part hereof.

Determination of the additional rates payable for the prescription drug coverage hereunder, and remittance of such rates, will be in accordance with the rating and remittance practices currently in effect between the Employer and the Participating Plans. Such rating and remittance practices may be modified from time to time.

Memorandum—Auto Prescription Drug Program

This Addendum to the Master Group Operating Agreement shall be effective at 12:01 a.m., October 1, 1969 and shall continue in force and effect thereafter until terminated in accordance with the terms and conditions of the Master Group Operating Agreement.

In WITNESS WHEREOF, the parties hereto have caused this Addendum to be executed in duplicate, the date and year first above written.

Chrysler Corporation	Michigan Hospital Service
_____	_____
(Name)	(Name)
_____	_____
(Title)	(Title)

Michigan Medical Service

_____

(Name)

_____

(Title)

Memorandum—Auto Prescription Drug Program

NATIONAL ACCOUNT PROGRAM

MASTER GROUP OPERATING AGREEMENT

CHRYSLER CORPORATION

EXHIBIT "A"

ADDENDUM NO. 1

Blue Cross and Blue Shield Plan Areas Where Prescription Drug Coverage is to be Provided

Blue Cross Plan Areas	*Blue Shield Plan Areas*
Alabama	Alabama
Arizona	Arizona
California, Los Angeles	
California, Oakland	
	California, San Francisco
Colorado, Denver	Colorado, Denver
Delaware	Delaware
Illinois, Chicago (Includes Rockford Area)	Illinois, Rockford
Indiana	Indiana
Massachusetts	Massachusetts
Michigan	Michigan
Minnesota	Minnesota
Missouri, Kansas City	Missouri, Kansas City
New Jersey	New Jersey
New York, New York	New York, New York
Oregon	Oregon
	Pennsylvania, Camp Hill
Pennsylvania, Pittsburgh	
Pennsylvania, Wilkes-Barre	
Texas	Texas
Virginia, Richmond	Virginia, Richmond

Memorandum—Auto Prescription Drug Program

NATIONAL ACCOUNT PROGRAM

MASTER GROUP OPERATING AGREEMENT

ADDENDUM NO. 1

FORD MOTOR COMPANY

This Addendum dated ———————— 1969, is between FORD MOTOR COMPANY (hereinafter referred to as the "Employer") and MICHIGAN HOSPITAL SERVICE, a Michigan nonprofit corporation existing and operating under the provisions of Act 109 P.A. Michigan 1939, as amended, (hereinafter referred to as "Hospital Service") and MICHIGAN MEDICAL SERVICE, a Michigan nonprofit corporation organized and existing under the provisions of Act 108 P.A. Michigan 1939, as amended (hereinafter referred to as "Medical Service").

Hospital Service and Medical Service agree to furnish or cause to be furnished for Enrollees (except persons covered as sponsored dependents, retirees and their dependents, and surviving spouses of employees, whether active or retired at date of death, and their dependents) the benefits under the Hospital Service and Medical Service Prescription Drug Group Benefit Certificate, form 87 (50-535).

The Blue Cross and Blue Shield Plan areas where prescription drug coverage is to be provided are set forth in Addendum No. 1 to Exhibit "A", which is attached hereto and by reference made a part hereof.

Rating and additional rate remittance for the prescription drug coverage hereunder will be in accordance with the rate equalization arrangement which became effective on January 1, 1967 between the Employer, Hospital Service, and Medical Service, as the same may from time to time be modified.

Memorandum—Auto Prescription Drug Program

This Addendum to the Master Group Operating Agreement shall be effective at 12:01 a.m., October 1, 1969 and shall continue in force and effect thereafter until terminated in accordance with the terms and conditions of the Master Group Operating Agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Addendum to be executed in duplicate, the date and year first above written.

Ford Motor Company	Michigan Hospital Service
_____	_____
(Name)	(Name)
_____	_____
(Title)	(Title)

Michigan Medical Service

_____

(Name)

_____

(Title)

Memorandum—Auto Prescription Drug Program

NATIONAL ACCOUNT PROGRAM

MASTER GROUP OPERATING AGREEMENT

FORD MOTOR COMPANY

EXHIBIT "A"

ADDENDUM NO. 1

Blue Cross and Blue Shield Plan Areas Where Prescription Drug Coverage is to be Provided

Blue Cross Plan Areas	*Blue Shield Plan Areas*
Alabama	Alabama
Arizona	Arizona
California, Los Angeles	
California, Oakland	
	California, San Francisco
Colorado	Colorado
District of Columbia	District of Columbia
Florida	Florida
Indiana	Indiana
Iowa, Des Moines	Iowa, Des Moines
Kentucky	Kentucky
Louisiana, Baton Rouge	BC underwriters coverage
Maryland	Maryland
Massachusetts	Massachusetts
Michigan	Michigan
Minnesota	Minnesota
Missouri, Kansas City	Missouri, Kansas City
Nebraska	Nebraska
New Jersey	New Jersey
New York, Albany	New York, Albany
New York, Buffalo	New York, Buffalo
New York, New York	New York, New York
North Dakota	North Dakota
Ohio, Cleveland	Ohio, Cleveland
Pennsylvania, Philadelphia	
Pennsylvania, Pittsburgh	Pennsylvania, Camp Hill

Memorandum—Auto Prescription Drug Program

Blue Cross Plan Areas	*Blue Shield Plan Areas*
Texas	Texas
Utah	Utah
Virginia, Richmond	Virginia, Richmond
Washington, Seattle	Washington, Seattle
Wisconsin, Milwaukee	Wisconsin, Milwaukee

Memorandum—Auto Prescription Drug Program

NATIONAL ACCOUNT PROGRAM

MASTER GROUP OPERATING AGREEMENT

ADDENDUM NO. 1

GENERAL MOTORS CORPORATION

This Addendum dated ———————— 1969, is between GENERAL MOTORS CORPORATION (hereinafter referred to as the "Employer") and MICHIGAN HOSPITAL SERVICE, a Michigan nonprofit corporation existing and operating under the provisions of Act 109 P.A. Michigan 1939, as amended, (hereinafter referred to as "Hospital Service") and MICHIGAN MEDICAL SERVICE, a Michigan nonprofit corporation organized and existing under the provisions of Act 108 P.A. Michigan, 1939, as amended (hereinafter referred to as "Medical Service").

Hospital Service and Medical Service agree to furnish or cause to be furnished for Members (except persons covered as sponsored dependents, retirees and their dependents, and surviving spouses of employees, whether active or retired at date of death, and their dependents) the benefits under the Hospital Service and Medical Service Prescription Drug Group Benefit Program Certificate, form 87 (50-535).

The Blue Cross and Blue Shield Plan areas where prescription drug coverage is to be provided are set forth in Addendum No. 1 to Exhibit "A", which is attached hereto and by reference made a part hereof.

Determination of the additional rates payable for the prescription drug coverage hereunder, and remittance therefor, will be in accordance with the rating and remittance methods currently in effect between the Em-

ployer and each Participating Blue Cross and Blue Shield Plan and subject to review and approval by the Employer. Such rating and remittance methods may be reviewed and modified from time to time as agreed to by the Employer, and the appropriate Blue Cross or Blue Shield Plan.

This Addendum to the Master Group Operating Agreement shall be effective at 12:01 a.m., October 1, 1969 and shall continue in force and effect thereafter until terminated in accordance with the terms and conditions of the Master Group Operating Agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Addendum to be executed in duplicate, the date and year first above written.

General Motors Corporation	Michigan Hospital Service
_____	_____
(Name)	(Name)
_____	_____
(Title)	(Title)
	Michigan Medical Service
	_____
	(Name)
	_____
	(Title)

NATIONAL ACCOUNT PROGRAM

MASTER GROUP OPERATING AGREEMENT

GENERAL MOTORS CORPORATION

EXHIBIT "A"

ADDENDUM NO. 1

Blue Cross and Blue Shield Plan Areas Where Prescription Drug Coverage is to be Provided

Blue Cross Plan Areas	*Blue Shield Plan Areas*
Cailfornia, Los Angeles	
California, Oakland	
	California, San Francisco
Colorado	Colorado
D.C., Washington	D.C., Washington
Florida	Florida
Indiana	Indiana
Iowa, Des Moines	Iowa, Des Moines
Kansas	Kansas
Kentucky	Kentucky
Maryland	Maryland
Massachusetts	Massachusetts
Michigan	Michigan
	Minnesota, Minneapolis
Minnesota, St. Paul	
Missouri, Kansas City	Missouri, Kansas City
Montana, Great Falls	Montana, Helena
Nebraska	Nebraska
New Jersey	New Jersey
New York, Buffalo	New York, Buffalo
New York, New York	New York, New York
New York, Rochester	New York, Rochester
New York, Syracuse	New York, Syracuse
New York, Utica	New York, Utica
North Dakota, Fargo	North Dakota, Fargo
Ohio, Cleveland	Ohio, Cleveland

Memorandum—Auto Prescription Drug Program

Blue Cross Plan Areas	*Blue Shield Plan Areas*
Oregon, Portland	Oregon, Portland
	Pennsylvania, Camp Hill
Pennsylvania, Philadelphia	
Pennsylvania, Pittsburgh	
Pennsylvania, Wilkes-Barre	
Utah	Utah
Virginia, Richmond	Virginia, Richmond
	Wisconsin, Madison
Wisconsin, Milwaukee	Wisconsin, Milwaukee

Memorandum—Auto Prescription Drug Program

PARTICIPATING PROVIDER CAMPAIGNS

Section 2 of the BCA/NABSP Prescription Drug Program Manual discusses certain aspects of Provider Relations as they pertain to the drug program. This information should be helpful in designing local participating Provider campaigns.

Two very important factors to participating Providers are the establishment of the dispensing fee and the determination of acquisition costs. Information about these factors may be found in the material under Tab 3 of this booklet.

Principle administrative items affecting the Michigan participating Provider campaign include the following:

—Obtaining approval of certificate language

—Issuing press releases to local trade publications announcing the program

—Contacting pharmacies through letters and regional meetings explaining the program

—Obtaining signed Participating Pharmacy Agreements (see attached example of Michigan's agreement)

—Supplying administrative mechanisms (imprinters, claims forms etc.) to the participating Providers.

DRAFT
Michigan Participating
Provider Agreement

April 15, 1969

SERVICE BENEFIT
PRESCRIPTION DRUG PROGRAM
PARTICIPATION AGREEMENT

Date _____

This Agreement made between Michigan Blue Shield, acting on behalf of Michigan Blue Shield and Michigan Blue Cross, and

_____

(Name and Address of Pharmacy)

(a corporation) (partnership) (Proprietorship) doing business under Michigan Pharmacy License No. _____ _____:

1. The Participating Pharmacy agrees that all pharmacists providing services on its behalf are to be considered participating pharmacists.
2. The participating pharmacy agrees to provide services to subscribers in accordance with the terms of the subscriber's contract as described in the Michigan Blue Cross-Michigan Blue Shield Pharmacy Manual at the time of service.
3. Michigan Blue Cross-Michigan Blue Shield agree to pay to the Participating Pharmacy for all valid claims submitted by the Participating Pharmacy, and the Participating Pharmacy agrees to accept as full payment for services performed, according to the following reimbursement mechanism:

   Reimbursement, except for Insulin, will be the total of net acquisition cost as defined by Michigan Blue Cross-Michigan Blue Shield, plus the current professional fee payable by Michigan Blue Cross-Michigan Blue Shield for pharmaceutical services as stated in the Michigan Blue Cross-Michigan Blue Shield Pharmacy Manual at the time services are performed, less the co-payment amount payable by the subscriber. Claims for Insulin will be reimbursed on the basis of the lesser of the provider's usual and customary charges, or cost plus professional fee.

4. Michigan Blue Cross-Michigan Blue Shield agree to provide the Participating Pharmacy with a manual in which the contracted pharmaceutical benefits of the subscriber will be listed and the co-payment liability of the subscriber stated.
5. All contracts or transactions in which the Participating Pharmacy engages involving dispensing of drugs shall be between that Pharmacy and the patient, and Michigan Blue Cross-Michigan Blue Shield shall not be a party thereto.
6. Michigan Blue Cross-Michigan Blue Shield shall have the right to inspect all records pertaining to Michigan Blue Cross-Michigan Blue Shield Drug Program subscribers.
7. This agreement may be terminated at any time by either party by giving at least fifteen days written notice to the other party.
8. The Participating Pharmacy agrees not to engage in any advertising relative to the Michigan Blue Cross-Michigan Blue Shield Drug Program without prior approval of Michigan Blue Cross-Michigan Blue Shield.

Michigan Blue Shield	Participating Pharmacy
By _____	By _____
President	Official Title _____

IDENTIFICATION CARDS

Development of Identification Cards is a local Plan decision as far as size, style, and content are concerned. Some Plans may have already accommodated the Prescription Drug Coverage on their cards. Those who have not already done so should consider the use of one card which reflects the total program (hospital, medical, surgical, and prescription drugs). Separate cards for prescription drugs may be used but the customers have expressed a preference for one card.

Issuance should occur prior to the October 1, 1969 effective date, and distribution is to be handled in accordance with established local practice. The matter of National Identification Cards for Auto is being explored and adoption of such a card may be requested in the future.

CLAIMS PROCESSING GUIDELINES

Plans desiring guidance in developing a Claims Processing System are referred to in Sections 7, 8, and 9 of the BCA/NABSP Prescription Drug Program Manual, which detail various systems. The method to be adopted is dependent upon anticipated claims volume and related cost considerations.

The Michigan system of claims administration will rely on a high level of mechanical technology, including the use of plastic identification cards, imprinters, and optical scanning equipment for data conversion and utilization record maintenance.

Two separate reporting forms (see attachments "A" and "B") will be utilized in claiming payment under the Drug Program. Form "A" is for use by Michigan Participating

Providers when claiming payment direct. Form "B" will generate payment to the subscriber. (Please note the Claim Forms do not include any provision for C.O.B. It may be necessary to incorporate this phase of the program on the forms.)

Basic validation and editing functions will be performed by Michigan through the use of optical scanning equipment which will reject incomplete or invalid claims and automatically convert acceptable claims to magnetic tape. Processing of claims to conclusion, either payment or other disposition, will be performed in a manner similar to the basic benefits program for both eligibility and utilization record maintenance. Pricing of eligible Drug claims will be performed by computer, in accordance with the program benefits, limitations, member's liability and all other contributing factors.

Check writing for acceptable claims will occur weekly rather than bi-weekly as in the case of the basic Michigan benefit program. Other similarities to existing procedures will include record retention via microfilming and historical records, a status inquiry mechanism, and statistical data retrieval.

To the degree possible, the Michigan systems described have been finalized and administration will be carried out accordingly. It should be recognized, however, that the need for modifications may become apparent as the program implementation date is approached, and that subsequent changes may be necessary.

Attachment "A"
Draft

TYPE ALL ENTRIES — MAIL PART 2 (CLAIM FORM) TO:
MICHIGAN BLUE SHIELD
P.O. BOX 500
DETROIT, MICHIGAN 48231

IMPORTANT: DO NOT WRITE IN SHADED AREAS (MBS USE ONLY)

SUBSCRIBER NAME
EFFECTIVE DATE CURRENT COVERAGE
GROUP NO.
SERVICE CODE
PAYMENT TO PHARMACY
II. PROVIDER NAME AND ADDRESS
CONTRACT NUMBER
PLAN CODE
DATE OF SERVICE MO. DAY YEAR
PROVIDER NUMBER
REFERENCE NUMBER

III. REL. CODE	AGE	PRESCRIPTION NUMBER	NEW/ REFILL	DRUG CODE*	METRIC QUANTITY	ACQUISITION COST	+ DISPENSING FEE	= SUB TOTAL	- LESS CO PAY	= AMOUNT DUE	ACCT. NO.	TRANS CODE	TRANS CODE	FLAG	

FOR MBS USE ONLY

IV. *DRUG DESCRIPTION, DOSAGE FORM, STRENGTH, (REQUIRED ONLY IN ABSENCE OF DRUG CODE)

ELIGIBILITY VERIFIED

LETTER SENT

V. THIS SECTION TO BE COMPLETED BY PHARMACIST

ORIGINAL REFILL CODES: 0 FOR ORIGINAL PRESCRIPTION; 1 FOR FIRST REFILL; 2 FOR SECOND REFILL; 3 FOR THIRD REFILL, ETC.

PHARMACISTS CERTIFICATION STATEMENT:

"I CERTIFY THAT THE SERVICE DESCRIBED ON THIS CLAIM HAS BEEN PROVIDED IN ACCORDANCE WITH THE PARTICIPATING PHARMACY AGREEMENT AND CONDITIONS FOR PARTICIPATION IN THE MICHIGAN BLUE CROSS/BLUE SHIELD DRUG PROGRAM. THE CHARGES FOR THE SERVICES HEREIN CONSTITUTES THE FULL AND COMPLETE CHARGE FOR THE SERVICE PERFORMED."

X
PHARMACIST SIGNATURE

VI. THIS SECTION TO BE COMPLETED BY RECIPIENT.

PATIENT NAME

CIRCLE APPROPRIATE NUMBER TO INDICATE SUBSCRIBER OR PATIENT'S RELATIONSHIP TO THE SUBSCRIBER.

1 MALE SUBSCRIBER
2 FEMALE SUBSCRIBER
3 MALE SPOUSE
4 FEMALE SPOUSE
5 MALE DEPENDENT
6 FEMALE DEPENDENT

PRINT AGE OF PATIENT IN THIS BOX

CERTIFICATION STATEMENT

"I CERTIFY THAT THE PATIENT FOR WHOM THIS CLAIM IS MADE IS AN ELIGIBLE MEMBER IN THE MICHIGAN BLUE CROSS/BLUE SHIELD DRUG PROGRAM AND THAT SAID PATIENT IS ENTITLED TO BENEFITS UNDER THAT PROGRAM IN THE EVENT OF A CO ORDINATION OF BENEFITS PROVISION AND THAT THE PRESCRIPTION IS FOR THE SOLE USE OF THAT MEMBER. I UNDERSTAND THAT ANY FRAUDULENT USE OF THIS CARD CAN TERMINATE ALL BLUE CROSS/BLUE SHIELD COVERAGE."

X
RECIPIENT SIGNATURE

Attachment "B"
Draft

PRINT OR PLEASE TYPE ALL ENTRIES — MAIL PART 2 (CLAIM FORM) TO:
MICHIGAN BLUE SHIELD
P.O. BOX
DETROIT, MICHIGAN 48231

IMPORTANT: DO NOT WRITE IN SHADED AREAS (MBS USE ONLY)

I. SUBSCRIBER NAME
EFFECTIVE DATE CURRENT COVERAGE
GROUP NO.
SERVICE CODE
PAYMENT TO SUBSCRIBER
CONTRACT NUMBER
PLAN CODE
DATE OF SERVICE MO. DAY YEAR
II. PROVIDER NAME AND ADDRESS
PROVIDER NUMBER
REFERENCE NUMBER

III. REL. CODE	AGE	PRESCRIPTION NUMBER	NEW/ REFILL	DRUG CODE	METRIC QUANTITY	TOTAL CHARGE	ACCT. NO.	TRANS CODE	TRANS CODE	FLAG

FOR MBS USE ONLY

IV. DRUG DESCRIPTION, DOSAGE, AND STRENGTH

ELIGIBILITY VERIFIED

LETTER SENT

V. THIS SECTION TO BE COMPLETED BY PHARMACIST

ORIGINAL REFILL CODES: 0 FOR ORIGINAL PRESCRIPTION; 1 FOR FIRST REFILL; 2 FOR SECOND REFILL; 3 FOR THIRD REFILL, ETC.

PAYMENT FOR THE ABOVE PRESCRIPTION SERVICE WILL BE PAID TO THE SUBSCRIBER AND SENT TO THE ADDRESS GIVEN BELOW. CHECK WILL BE SENT TO THIS ADDRESS.

SUBSCRIBER'S LAST NAME — FIRST — INITIAL

STREET

CITY — STATE — ZIP CODE

VI.

PATIENT NAME

MARK APPROPRIATE NUMBER TO INDICATE RELATIONSHIP TO SUBSCRIBER AND PLACE IN "R" REL. CODE BOX ABOVE.

1 MALE SUBSCRIBER
2 FEMALE SUBSCRIBER
3 MALE SPOUSE
4 FEMALE SPOUSE
5 MALE DEPENDENT
6 FEMALE DEPENDENT

CERTIFICATION STATEMENT

"I CERTIFY THAT THE PATIENT FOR WHOM THIS CLAIM IS MADE IS AN ELIGIBLE MEMBER IN THE MICHIGAN BLUE CROSS/BLUE SHIELD DRUG PROGRAM AND THAT THE PRESCRIPTION IS FOR THE SOLE USE OF THAT MEMBER. I UNDERSTAND THAT ANY FRAUDULENT USE OF THIS CARD CAN TERMINATE ALL BLUE CROSS/BLUE SHIELD COVERAGE."

X
RECIPIENT SIGNATURE

ORIGINAL – RETAIN THIS COPY FOR YOUR RECORDS

DUPLICATE – CLAIM FORM – MAIL TO BLUE SHIELD

TRIPLICATE – STATUS INQUIRY

DESCRIPTIVE LITERATURE

Subscriber literature covering the Prescription Drug Program will be developed for all Plan areas by Michigan Blue Cross and Blue Shield. At the present time, it appears that such material will be in the form of separate pamphlets rather than a complete rewrite of the Employee Booklets. In accordance with the Implementation Timetable, the literature is scheduled for distribution by September 1, 1969. The method of distribution has not been decided; however, it will probably be handled similar to the booklet distribution in late 1968 and early 1969.

COORDINATION OF BENEFITS

The specifications for the prescription drug program contain a Coordination of Benefits provision. Detailed discussions on this subject have not yet been held with the Customer, however, it is assumed that the Coordination of Benefits principles already established for hospital, surgical, medical coverage will also apply to the Drug program. The large volume of low cost claims associated with drugs creates practical administrative difficulties. Currently, three (3) methods of administering this aspect of the program are under consideration. They are:

1. Investigate drug claims which exceed a fixed dollar limit. This method would be economical; however, using a dollar limit would not necessarily provide effective investigation of drug claims as a patient could have one large drug bill in a given year which would be less than an accumulation of smaller drug bills by another patient in the same year.
2. Piggy-back on other Coordination of Benefits investigations (e.g., investigations on in-patient, out-

patient and doctor's service cases). The cost of this method would be minimal and recovery potential relatively good since these would be cases which were already being investigated and where recovery was a definite possibility.

3. Investigate according to specific diagnoses. This method would be economical and would provide information regarding patients who use a large volume of costly drugs, by selecting diagnoses which normally require Prescription Drugs (e.g., diabetes, chronic heart conditions, etc.).

As soon as details have been concluded, they will be communicated to Plans. In the meantime, to assist in discussions with the customer any comments or suggestions Plans may have will be appreciated.

DATA REQUIREMENTS

The Control Plans will be required to furnish each Account with financial and statistical data covering the Prescription Drug Program, for Participating Plans.

To meet this requirement, the current Data and Claims Reporting Requirements will be revised. The changes are: 1) Revision of the Income Report; 2) Revision of the Expense Report; and 3) Inclusion of a new Monthly Drug Report. The Contract Exposure Report will be retained in its present form. National Paid Claim Cards will not be used for the Drug Program.

The reports should be submitted to:

(a) Contract Exposure, Income, and Expense Reports:

Michigan Blue Cross
441 East Jefferson Avenue
Detroit, Michigan 48226

Memorandum—Auto Prescription Drug Program

Attention: Mr. D. P. Mamuscia
Data & Rating Specialist
Auto Groups Department

(b) Monthly Drug Reports:
Michigan Blue Shield
441 East Jefferson Avenue
Detroit, Michigan 48226

Attention: Manager
Accounting Department

Copies of the report forms and instructions follow

CONTRACT EXPOSURE REPORT

Participating Plans are required to report contract exposure for the months of June and December each year.

For Ford and General Motors, separate reports are to be prepared for (1) Hourly and (2) Salaried contracts. For Chrysler Contracts, the distinction is between Bargaining and Non-bargaining units. Although there are some salaried bargaining employees, Plans should consider *all* bargaining Chrysler units as Hourly and *all* Chrysler non-bargaining units as Salaried when completing this report.

Participating Plans should use only those enrollment classifications applicable to local Plan definitions; i.e., if a Participating Plan does not employ the classification of "Mixed Coverage Contracts", this section will be left blank. However, Plans must accurately segregate their contracts and Sponsored Dependent Riders into the payroll locations listed. Any exceptions should be explained by a written attachment to the report.

Three copies of the Contract Exposure Reports are to be submitted to the Control Plans within 90 days following the reporting month.

Memorandum—Auto Prescription Drug Program

NATIONAL ACCOUNT PROGRAM
CONTRACT EXPOSURE REPORT

PARTICIPATING PLAN Plan Number	NAME OF ACCOUNT (BARG.) ☐ Hourly (NON-BARG.) ☐ Salaried	REPORTING PERIOD

ENROLLMENT CLASSIFICATION (Use Categories Applicable to Local Plan Definitions)	NUMBER OF CONTRACTS						
	ACTIVE EMPLOYEE	RETIRED EMPLOYEE	SURVIVING SPOUSE		RETIREE SURVIVING SPOUSE		TOTAL
			COMPANY PAID CONTRACTS	INDIVIDUAL PAID CONTRACTS	COMPANY PAID CONTRACTS	INDIVIDUAL PAID CONTRACTS	
REGULAR ONLY CONTRACTS (All members have regular coverage)							
INDIVIDUAL							
TWO PERSON							
FAMILY (two or more)							
FAMILY (three or more)							
TOTAL REGULAR ONLY							
COMPLEMENTARY ONLY CON. (All members have complementary coverage)							
INDIVIDUAL							
TWO PERSON							
TOTAL COMPLEMENTARY ONLY							
MIXED COVERAGE CONTRACTS							
TWO PERSON - One Regular Member, One Comp. Member							
FAMILY – With One Comp. Member							
FAMILY – With Two Comp. Members							
TOTAL MIXED CONTRACTS							
TOTAL CONTRACTS							
NUMBER OF MEMBERSHIP RIDERS							
SPONSORED DEPENDENTS							
REGULAR COVERAGE							
COMPLEMENTARY COVERAGE							
TOTAL							

Memorandum—Auto Prescription Drug Program

INCOME REPORT

This report need not be submitted for equalized accounts. The Income Reports are to be submitted to the Control Plan on a quarterly basis.

Report Items

1. All income should be reported by type of coverage (Hospital, Surgical-Medical, Prescription Drugs) and by payroll classification (Hourly vs. Salaried).
2. Earned Subscription Income—This will be a net figure based upon exposure for the quarter and any adjustments from previous periods.
3. Other Income Accruing to Account—This will be income exclusive of that based upon exposure for the quarter and any adjustments from previous periods.
4. Three copies of the Income Reports are to be submitted to the Control Plan within 60 days following the end of each quarter.

Memorandum—Auto Prescription Drug Program

NATIONAL ACCOUNT PROGRAM

EXPENSE REPORT

PARTICIPATING PLAN PLAN NO.	NAME OF ACCOUNT ☐ HOURLY (Barg.) ☐ SALARIED (Non-Barg.)	REPORTING PERIOD

Reserve for Claims Incurred but Unpaid

	Hospital Coverage	Surgical-Medical Coverage	Prescription Drug Coverage
Hourly			
Salaried			
Total			

Administrative Expenses

	Hospital Coverage	Surgical-Medical Coverage	Prescription Drug Coverage
Hourly			
Salaried			
Total			

Other Expenses

	Hospital Coverage	Surgical-Medical Coverage	Prescription Drug Coverage
Hourly			
Salaried			
Total			

Nature of Other Expenses

_____

_____

_____

_____

Memorandum—Auto Prescription Drug Program

EXPENSE REPORT

This report need not be submitted for equalized accounts. The Expense Reports are to be submitted on a calendar year basis.

Report Items

1. All items should be reported by type of coverage (Hospital, Surgical-Medical, Prescription Drugs) and by payroll classification (Hourly vs. Salaried).

2. Reserve for Claims Incurred but Unpaid—The figure representing the amount estimated by the Plan to cover this liability for the reporting period.

3. Administrative Expenses—Expenses that relate to the cost of performing the administrative functions involved. The amounts for claims paid and for those claims incurred but not yet paid, should be shown separately.

4. Other Expenses—This includes any expenses not related to the performance of administrative functions. An example would be the premium taxes that some Plans are required to pay. The nature of these other expenses should be explained in the space provided.

5. Those Blue Cross Plans who pay member hospitals on the basis of reimbursable costs and are involved with supplemental payments may use either of the following methods to report their total benefit payments:

   (1) On each claim, use (in columns 51-56) the percent of charges that you estimate to accurately reflect the final ratio of liability to charges.

Memorandum—Auto Prescription Drug Program

   (2) Submit, with the Expense report and reported by type of coverage and payroll classification, the supplemental amounts to be added to the initial benefit payments.

   Whichever method is used, any differences between the estimates submitted and actual amounts paid should be reported to the Control Plan so that the necessary adjustments can be made.

6. Three copies of the Expense Reports are to be submitted to the Control Plan within 90 days after the reporting period.

Memorandum—Auto Prescription Drug Program

NATIONAL ACCOUNT PROGRAM

INCOME REPORT

PARTICIPATING PLAN PLAN NO.	NAME OF ACCOUNT ☐ HOURLY (Barg.) ☐ SALARIED (Non-Barg.)	REPORTING PERIOD

Earned Subscription Income

	Hospital Coverage	Surgical-Medical Coverage	Prescription Drug Coverage
Hourly			
Salaried			
Total			

Other Income Accruing to Account

	Hospital Coverage	Surgical-Medical Coverage	Prescription Drug Coverage
Hourly			
Salaried			
Total			

Nature and Source of Other Income

Memorandum—Auto Prescription Drug Program

PLAN INVOICE FOR NATIONAL ACCOUNTS MONTHLY DRUG REPORT

(Completion Key)

A. CONTROL PLAN GROUP NUMBER—ENTER APPROPRIATE GROUP NUMBER PER LISTING ON PAGES 7.75-7.77 OF OPERATIONS MANUAL HSMD AUTO NATIONAL ACCOUNT PROGRAM

B. GROUP NAME—ENTER

"CHRYSLER CORPORATION"
"FORD MOTOR COMPANY"
"GENERAL MOTORS CORPORATION"

C. PLAN NUMBER—ENTER YOUR PLAN NUMBER

D. REPORT MONTH AND YEAR—ENTER THE MONTH AND YEAR FOR WHICH DATA IS BEING TRANSMITTED

E. "NO CLAIMS PAID" CHECK BOX—CHECK IF NO CLAIMS PAID DURING THE REPORT MONTH

F. NUMBER OF SERVICES (PRESCRIPTIONS) PAID—FOR SINGLE, TWO PERSON, FAMILY AND TOTAL, REPORT THE ACTUAL NUMBER OF PRESCRIPTIONS PAID

G. TOTAL AMOUNT PAID—FOR SINGLE, TWO PERSON, FAMILY AND TOTAL, REPORT THE ACTUAL AMOUNT PAID

Memorandum—Auto Prescription Drug Program

H. NUMBER OF CLAIMS PAID—FOR SINGLE, TWO PERSON, FAMILY AND TOTAL, REPORT THE ACTUAL NUMBER OF CLAIMS FORMS PROCESSED

I. PLAN NAME—ENTER YOUR PLAN'S NAME

J. CITY AND STATE—ENTER THE CITY AND STATE IN WHICH YOUR PLAN IS LOCATED

K. PREPARED BY (NAME AND TITLE)

L. DATE—ENTER DATE OF TRANSMISSION

Memorandum—Auto Prescription Drug Program

PLAN INVOICE FOR NATIONAL ACCOUNTS

MONTHLY DRUG REPORT

Control Plan Group Number A	Group Name B	Plan No. C	Report No + Yr D	☐ Check if No Claims Are Paid in the Report Month E

F Number of Services Paid	1	2	3	Total
G Total Amount Paid	$	$	$	$
H Number of Claims Paid				

Plan Name I	City and State J
Prepared by (Name and Title) K	Date L

INVOICE PREPARATION INSTRUCTIONS

1. Mail by the fifteenth of the month following the report month.
2. Submit one invoice for each group number per Operations Manual HSMD Auto National Account Program (Pages 7.75 - 7.77).
3. Mail to:

Michigan Blue Shield
441 East Jefferson Avenue
Detroit, Michigan 48226

Attention: Manager,
Accounting Department

1 = one person contract
2 = two person contract
3 = family contract

Memorandum—Auto Prescription Drug Program

RATING GUIDELINES

Plans will shortly be requested to complete Drug program rating questionnaires in respect to the program to become effiective October 1, 1969, for Chrysler, Ford, and General Motors.

The Chrysler and General Motors' questionnaires will request local plan rate calculations and rating assumptions.

The Ford questionnaire will outline the equalization proposal and request local plan participation.

For Chrysler and General Motors coverage, it is anticipated that the request will include questions on the following basic assumptions and calculations:

1. Cost per prescription.
2. Prescriptions per year.
3. Adjustment (if any) for non-participating pharmacies.
4. Adjustment (if any) for non-legend drugs.
5. Retention schedule.
6. Enrollment mix for a recent month.
7. Rating formula.

With respect to Chrysler and General Motors, the Michigan Plans intend to provide Drug program coverage based on "community" or manual rates for the initial rating period. Renewal rates will then be calculated on the basis of experience.

It is anticipated that the rating questionnaires will be sent to local plans on approximately May 10, 1969.

Memorandum—Auto Prescription Drug Program

FORD EQUALIZATION PROCEDURES

The Monthly Drug Report will also be used for reimbursement under the Ford Equalization Program. National Paid Claim Cards will not be utilized.

Details of the reimbursement formula are being finalized and will be distributed in the near future, along with a request for Plan Participation in the Equalization Program.

GENERAL MOTORS SALARIED EMPLOYEES

Although the General Motors salaried employees are not included in the National Account Program, Michigan Blue Cross and Blue Shield have been asked to coordinate implementation of a Prescription Drug Program for salaried personnel. The coverage is to be effective concurrent with the hourly-rate program October 1, 1969, and is subject to the same eligibility requirements (Sponsored Dependents, Retirees and their dependents, and Surviving Spouses and their dependents are excluded).

Plans should submit to the Control Plans (Auto Groups Department, Michigan Blue Cross) a statement signed by a local Plan official which identifies the Drug Program being proposed for salaried employees. It is expected that Plans will propose the same program being offered under the National Account Program.

Rating instructions regarding proposals for salaried employees will be distributed to Plans. Preliminary instructions have already been issued under Salaried Release 2, dated April 17, 1969.

Memorandum—Auto Prescription Drug Program

PLANS IN ATTENDANCE
WASHINGTON, D.C.
APRIL 22, 1969

BLUE CROSS	BLUE SHIELD
Connecticut, New Haven	Connecticut, New Haven
Delaware, Wilmington	Delaware, Wilmington
District of Columbia	District of Columbia
Kentucky, Louisville	Kentucky, Louisville
Maine, Portland	Maine, Portland
Maryland, Baltimore	Maryland, Baltimore
Massachusetts, Boston	Massachusetts, Boston
New Jersey, Newark	New Jersey, Newark
New York, Albany	New York, Albany
New York, Buffalo	New York, Buffalo
New York, New York	New York, New York
New York, Rochester	New York, Rochester
New York, Syracuse	New York, Syracuse
Pennsylvania, Allentown	Pennsylvania, Camp Hill
Pennsylvania, Harrisburg	
Pennsylvania, Philadelphia	
Pennsylvania, Pittsburgh	
Pennsylvania, Wilkes-Barre	
West Virginia, Wheeling	West Virginia, Wheeling

Blue Cross Association
National Association of Blue Shield Plans

PLANS IN ATTENDANCE
ATLANTA, GEORGIA MEETING
APRIL 24, 1969

BLUE CROSS	BLUE SHIELD
Alabama, Birmingham	Alabama, Birmingham
Florida, Jacksonville	Florida, Jacksonville
Georgia, Atlanta	
Georgia, Columbus	Georgia, Columbus
Louisiana, New Orleans	Louisiana, Baton Rouge
Missouri, Kansas City	
North Carolina, Durham	

Blue Cross Association
National Association of Blue Shield Plans

Memorandum—Auto Prescription Drug Program

PLANS IN ATTENDANCE
SAN FRANCISCO MEETING
APRIL 29, 1969

BLUE CROSS	BLUE SHIELD
Arizona, Phoenix	Arizona, Phoenix
California, Los Angeles	California, San Francisco
California, Oakland	
Colorado, Denver	Colorado, Denver
Missouri, St. Louis	
Montana, Great Falls	Montana, Helena
Oklahoma, Tulsa	
Oregon, Portland	Oregon, Portland
Texas, Dallas	Texas, Dallas
Utah, Salt Lake City	
Washington, Seattle	Washington, Seattle
Wyoming, Cheyenne	Wyoming, Cheyenne

Blue Cross Association
National Association of Blue Shield Plans

PLANS IN ATTENDANCE
CHICAGO, ILLINOIS MEETING
MAY 1, 1969

BLUE CROSS	BLUE SHIELD
Illinois, Chicago	Illinois, Rockford
Indiana, Indianapolis	Indiana, Indianapolis
Iowa, Des Moines	Iowa, Des Moines
Kentucky, Louisville	Kentucky, Louisville
Michigan, Detroit	Michigan, Detroit
Minnesota, St. Paul	Minnesota, Minneapolis
Nebraska, Omaha	Nebraska, Omaha
North Dakota, Fargo	North Dakota, Fargo
Ohio, Cincinnati	
Ohio, Cleveland	Ohio, Cleveland
Ohio, Columbus	Ohio, Columbus
Ohio, Toledo	
Virginia, Richmond	Wisconsin, Milwaukee
Wisconsin, Milwaukee	Wisconsin, Madison

Blue Cross Association
National Association of Blue Shield Plans

LETTER FROM M. C. ROTTER TO TOM L. BEAUCHAMP, JR. DATED MAY 28, 1968 ("EXHIBIT 32" TO DEPOSITION OF JUDITH M. JOHNSON, NOVEMBER 20, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

[LOGO]

NATIONAL ASSOCIATION OF BLUE SHIELD PLANS
211 East Chicago Ave., Chicago, Ill. 60611
Phone (312) 943-8181

May 28, 1968

Mr. Tom L. Beauchamp, Jr., President
Group Life & Health Insurance Co.
Main at North Central Expressway
Dallas, Texas 75222

Re: Drug Program—Indemnity Areas

Dear Tom:

For areas like yours who are faced with the auto "service" drug program, I have a germ of an idea (which you may have already discarded) hinged mainly on providing a greater indemnity to pharmacies (acquisition cost plus dispensing fee) because of agreement to use a "bulk or simplified" accounting base; i.e., more benefit because of lesser administrative cost. The mass accounting agreement would then serve like a participating agreement.

1. On the subscriber contract the indemnity would be 75% of usual and customary, subject to the provision that Blue Shield, under a facility of payment clause, shall extend indemnity, to the extent that a subscriber need pay no more than the deductible for such item, for drugs billed for by and payable to all pharmacies agreeing to Blue Shield's mass claims accounting agreement, as may be established by Blue Shield.

The basic claims payment clause would be to pay the subscriber or, by using a facility of payment clause, the pharmacy. The company's option to use the facility of payment clause would uniformly be for those pharmacies having a mass accounting agreement. I think it would be best to draft the contract so that the Insurance Board would require filing of the mass accounting agreement to strengthen your base on antitrust. Drafting problems will get sticky here, but let's pass on that for now.

2. The mass accounting agreement probably should have self-serving whereas clauses emphasizing Blue Shield's intent to offer coverage, desire to relate payments to providers for these services, and the need to simplify administration and accounting in the public interest. The basic agreement would be that the accounting basis of indemnification under the facility of payment clause of the subscriber contract, for Blue Shield subscribers for services rendered by the pharmacy, would be acquisition cost plus dispensing fee in the aggregate for all services within a reporting period and that the pharmacy would make no charge to the subscriber in excess of the deductible. The pharmacy's quid pro quo is "averaging", bulk submissions and payment to him.

Tom, there are a lot of holes in this, but the alternative is paying usual and customary—and praying.

Sincerely,

/s/ M. C. Rotter
M. C. ROTTER

EXCERPTS FROM DEPOSITION OF LEE HELIS, NOVEMBER 21, 1975

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

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[4] DIRECT EXAMINATION

BY MR. PULLEN:

Q Would you state your name, please?
A Lee Helis.
Q How old are you, Mr. Helis?
A Thirty years old.
MR. KAISER: Let's go off the record.

(A discussion was had off the record.)

Q (By Mr. Pullen) What is your home address?
A 3326 Blueridge Lane, Garland, Texas.
Q Who is your present employer?
A Blue Cross-Blue Shield of Texas.
Q Any particular company?
A Group Hospital Service, Incorporated.
Q How long have you been employed by them?
A Eight years.
Q Prior to that time were you employed by any other organization on a full-time basis?
A Yes, I was.
Q What was that?
[5] A Texas Instruments.
Q Do you have any academic training?
A What do you mean by academic training?
Q College.
A Yes, sir, I do.
Q Where was that?

Excerpts From Deposition of Lee Helis

A Southern Methodist University and North Texas State University.
Q Did you get a degree?
A No, I did not.
Q How many years were you in school?
A Approximately three years.
Q Since you've been employed by your present employer what type of work have you done?
A I have primarily been in claims administrative type work.
Q Any particular type of coverage?
A All types of coverage.
Q All right. What is your present title?
A Manager of regular claims.
Q What does that include?
A That includes two areas of responsibility in our claims division one being our Blue Cross Claims Payment Unit and the other being Blue Shield's Claim Payment Unit.
[6] Q What is encompassed in the Blue Cross claims?
A Primarily hospital claims.
Q All right. That would be for hospital services and drugs furnished to people while they're in the hospital, this type—
A Yes, sir.
Q Does it include the doctor's portion?
A Not in the hospital claim section, no, sir.
Q All right. Now, in the Blue Shield claim area what do you do there; what type of things?
A This deals primarily with the physician file claims.
Q Do you have anything to do with the claims under the prepaid prescription coverage?
A Not any longer, no, sir.
Q When did that stop?
A October the 1st of this year.

Excerpts From Deposition of Lee Helis

Q How long were you involved in the Blue Shield prepaid prescription claims?

A Since May the 1st, 1972.

Q What exactly did you do in connection with the prepaid prescription claims?

A Okay. Now, can you give me a little better definition of exactly what you want in relation to that?

Q Well, I just want to know generally everything [7] you do in your job or what you have done.

A Okay. Does this include from the time the claim comes into the office until the time a check is written up; this type of detail?

MR. KAISER: I think it's just talking about your particular function.

THE WITNESS: My past function, in other words?

Q (By Mr. Pullen) Yes.

A Okay. At the time I was serving as manager of Special Claims Department of course this is where the prescription drug claims are handled presently—more of a consulting type position than anything else. We have front line supervision type people that deal directly with the prescription drug claims.

Q How many people do you have in that division now that deal with prescription drug claims?

A Approximately six people.

Q Six?

A Yes.

* * * *

[9] Q Do you have any idea how many claims your outfit handled under the prepaid prescription drug program a month?

A Approximately 31,000 claims per month.

Q Would this be true from '72 through the end of October—

A No, sir, it would not.

Excerpts From Deposition of Lee Helis

Q All right. Can you give me an idea what it was per month in 1972?

A Yes, sir, in the beginning it was approximately 1,000 claims per month.

MR. KAISER: You say in the beginning you meant in 1972?

THE WITNESS: Yes, sir, that's correct.

[10] Q (By Mr. Pullen) All right. Did that hold true pretty much through '72?

A No, sir, it did not.

Q All right. When did that change?

A Approximately 60 to 90 days into the program is when our volume started picking up considerably.

Q Okay. At the end of '72 what were you servicing per month?

A Approximately six to eight thousand claims per month.

Q This is just on the prepaid prescription drug program?

A That's correct.

Q All right. Now, how about in '73?

A Okay. Again we enrolled additional business and the claims volume increased to approximately twelve thousand to fifteen thousand claims a month.

Q All right. How about 1974?

A Okay. We again experienced an increase in the volume to approximately twenty to twenty-five thousand claims per month.

Q And through October of 1975?

A Approximately 31,000 claims per month.

* * * *

[13] Q (By Mr. Pullen) All right. So then the record, for example if Joel Pullen was a pharmacist and he participated in this program as a participating pharmacy

in your area there are no records other than just a list of the pharmacists, is that correct, who do participate?

A That is correct, yes, sir.

Q Now, how many claims do you receive each month on the average from non-participating pharmacists? Do you know the difference?

A Yes, I do.

Q Okay.

A Approximately 600 claims per month.

Q That's as of October?

A Yes, sir.

* * * *

[15] Q (By Mr. Pullen) I'm going to give you what has been marked as Deposition Exhibit 2 to Judy Johnson's deposition and on the next to the last page there is a small preprinted form and ask you to identify that.

A Okay. This is the form currently used by either the participating pharmacy or the subscriber to file a prescription drug claim.

Q All right. And the susbcriber would file where he's purchased his prescription at a non-participating pharmacy normally, is that correct?

A That's correct.

Q Do you have any information whatsoever as to the amount of claims paid monthly; the dollar volume?

A No, sir, I do not.

* * * *

[19] CROSS EXAMINATION

BY MR. KAISER:

Q Mr. Helis, when you were referring to this claim form which is attached to Deposition Exhibit Number 2 which was the portion of the deposition of Miss Judy Johnson you mentioned that that claim form was used

by participating pharmacies and by subscribers when they submit their individual claims?

A That's correct.

Q Tell me how subscribers normally send their claims in when they have gone to a non-participating pharmacist?

A Okay. Generally the subscriber when filing a claim form will not actualy fill out this claim form and submit it to us. We will generally receive a receipt similar to the one that I would get if I walked in off the street to a pharmacist and bought a prescription and paid it.

Q Well, when you receive that receipt what do you do with it?

A All right. Most of the time the receipts do [20] not have enough information on them to actually process a claim. At this point in time we generally have to go back to the subscriber and ask him specific questions to get the necessary information. When this is received back we have to manually and physically fill out the claim form for that subscriber and then perform our audit process and the process we talked about earlier.

Q Now, you have some data processing functions both with a claim from a participating pharmacist and with a claim from—that comes in from a subscriber who has purchased medication—

A That's correct.

Q —from a non-participating pharmacist?

A That's correct.

Q Which one has the greatest number of data processing functions?

A The claim filed by the subscriber from a non-participating pharmacy has the greater amount of work necessary to be done to complete the claim form. We have additional functions we have to perform since we have to manually set up the claim form ourselves in house. We have to check a couple of more areas of the claim form.

Excerpts From Deposition of Lee Helis

It causes our direct data entry people to also have a couple of extra strokes they have to perform.

[21] Q When you use the term direct data do you mean with the computers?

A Yes, sir, I do.

MR. KAISER: Let's go off the record for a minute.

(A discussion was had off the record.)

Q (By Mr. Kaiser) You said that when a claim comes in from an individual subscriber—as I understood your testimony you said you normally received just a prescription receipt?

A That's correct.

Q And that as I further understood your testimony most of the time those prescription receipts did not contain the necessary or the required information for processing claims, is that correct?

A That's correct.

Q And then I believe you testified that you would have to go back to the subscriber and obtain that necessary information, is that correct?

A That's correct.

Q How would you get back in touch with the subscriber?

A All right. We have specific form letters that we have set up to accomplish this purpose.

[22] Q Through the mails then?

A That is correct.

Q Can you say, Mr. Helis, that generally there is more work involved in processing a claim from a subscriber than from a participating pharmacist?

A Yes, sir.

MR. KAISER: I have no further questions.

MR. WALRAVEN: No questions.

Excerpts From Deposition of Lee Helis

REDIRECT EXAMINATION

BY MR. PULLEN:

Q I have a few more. These form letters, when you send those to the subscriber he doesn't get his check with those, does he?

A No, sir, he does not.

Q It takes him longer and it's more involved for a subscriber to get a claim paid when he deals with a non-participating pharmacist than if he deals with a participating pharmacist, is it not?

A That could be the case, yes, sir.

Q Well, generally isn't it the case?

A Yes, sir.

Q And on the average where you have a subscriber who deals with a non-participating pharmacist then he just sends you a copy of his prescription bill how long does it take before he gets his money—his reimburse-

[23] ment?

A Do you mean from the time we receive the information back in the shop?

Q Yes.

A Approximately ten days.

Q And usually in that ten-day period he'll get some correspondence from you?

A He'll receive his check specifically, yes.

Q Yes. But I mean if he just sends you this receipt which doesn't have all the information he'll get correspondence from you and then he'll have to answer that and give you the additional information you require to pay his claim?

A Yes, sir. Now, that process does not take ten days.

Q Yes.

A Correct.

Excerpts From Deposition of Lee Helis

Q It's a lot simpler for a subscriber if he goes to a participating pharmacist, isn't it?

A Yes, sir.

Q And his reimbursement differs to whether he goes to a participating pharmacist—

MR. KAISER: I'll object to the form. It's a statement rather than a question.

Q (By Mr. Pullen) All right. Does his [24] reimbursement differ?

A Yes, sir, it does.

Q All right. For example let's just say that we have a prescription that costs $6.00 and as I understand your participating drug plan $2.00 of that the subscriber pays?

A That's correct.

Q And if we assume an acquisition cost of $4.00 if he deals with a participating pharmacist who has signed a participating pharmacy agreement the pharmacist will get reimbursed the full $4.00?

A That's correct.

Q So all it cost the subscriber is $2.00?

A That's correct.

Q Now, if he deals with a non-participating pharmacist he still pays—he, being the subscriber pay the $2.00?

MR. KAISER: I think you're assuming that the non-participating pharmacist is going to charge only $6.00.

MR. PULLEN: I'm assuming the same charge just for the purpose of illustration.

MR. KAISER: Are you assuming that the non-participating pharmacist is going to charge the acquisition cost just as a participating pharmacist [25] would?

MR. PULLEN: I'm assuming the same charge. Then of the $4.00 how much will the subscriber get?

THE WITNESS: Seventy-five percent.

Excerpts From Deposition of Lee Helis

Q (By Mr. Pullen) So he'll get $3.00 there so he's out an extra dollar by dealing with a non-participating pharmacist under my example?

MR. KAISER: I'll object to the form of the question. It's a statement.

Q (By Mr. Pullen) Would he or wouldn't he be out an extra dollar if he deals with a non-participating pharmacist under my example?

A Yes, sir, he would be out.

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EXCERPTS FROM DEPOSITION OF STEVE G. McDONALD, NOVEMBER 21, 1975

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

* * * *

DIRECT EXAMINATION

[4] BY MR. PULLEN:

Q Would you state your name, please?
A Steve G. McDonald.
Q Where do you live, Mr. McDonald?
A Dallas.
Q Texas?
A Texas.
Q How old are you, sir?
A Thirty-four—thirty-five, excuse me. Thirty-five.
Q By whom are you presently employed?
A Group Hospital Service, Incorporated.

MR. KAISER: Counsel, at this point I might say Mr. McDonald is one of the staff counsel for Group Hospital Services, Group Life And Health Insurance Company and there may be an occasion—because of his position as staff counsel there may be an occasion in this deposition where I will have to envoke the attorney-client privilege in behalf of the client; just so we can understand why I [5] wanted to mention that at the outset.

Q (By Mr. Pullen) All right. Now, if your employer at this time is Group—
A Hospital Service, Incorporated.
Q What does that company do?
A That corporation is also known as Blue Cross of Texas. It's a non-profit hospital service corporation organized under Chapter 20 of the Texas Insurance Code.
Q All right. Have you always worked for that corporation?

Excerpts from Deposition of Steve G. McDonald

A I have been here for several years. I have had previous employers.
Q All right. Well, how long have you worked for Group Hospital Service, Inc.?
A I've been employed since December of 1960 with the exception of a nine-month period in 1963.
Q Where would that nine months have been?
A It would have been when I was attending school full time. The rest of the time it was at night.
Q When did you receive your law degree?
A January of 1966.
Q And you're admitted to the Texas State Bar?
A Yes.
Q Prior to the time you got your law degree what type of work were you doing at Group Hospital Service, [6] Inc.?
A Well, from December of 1960 until either December of '62 or January of '63 I was employed in the subscriber accounts department which was the department that handled our group premium billings employed in a clerical capacity. I terminated at that time and had begun law school the prior September at night. I converted to a day student and attended for nine months and in September of 1963 I was re-employed as a management trainee and was employed in that capacity until I graduated from law school and was assigned to the legal division as an associate counsel.
Q All right. You've been in the legal division how many years roughly?
A Well, it would be—
Q Nine?
A —nine years.
Q All right. What type of legal work have you done in the legal division?
A Well, it has been, you know, a wide variety of general corporate legal activities. I suppose the ma-

jority of my time has been involved in drafting and development of contract forms; the insurance documents that we issue.

Q By contract forms or insurance documents [7] would that include the insurance policy forms?

A Yes.

Q All right. Does it also include the Participating Drug Pharmacy Agreement which is Exhibit 1 to Miss Judy Johnson's deposition?

A I was involved in the drafting of that, yes.

Q All right. Now, are you also involved with the filings or approvals of various insurance documents with the commissioner of insurance of the State of Texas?

A Yes, I am.

Q All right. Mr. McDonald, I wish you would explain for me the corporate structure of the Blue Cross-Blue Shield Companies; for example I believe you worked for Group Hospital Service, Inc.—the Defendant here is Group Life And Health Insurance Company. Could you tell me about them and any other companies that come under the Blue Cross-Blue Shield Group?

A There are three corporations in our operation. We have Group Hospital Service, Incorporated which I described previously; Group Life And Health Insurance Company which is a legal reserve stock life insurance company organized under Chapter 3 of the Texas Insurance Code which is owned by Group Hospital Service, [8] Incorporated and we have Group Medical And Surgical Service which is a state-wide mutual assessment company organized under Chapter 14 of the Insurance Code. Blue Cross as I mentioned previously is authorized as a Blue Cross Plan by the Blue Cross Association and operates as Blue Cross of Texas. Group Life And Health Insurance Company and Group Medical And Surgical Service are Blue Shield Plans as authorized by the National Association of Blue Shield Plans and are known as Blue Shield of Texas.

Q All right. Now, you mentioned that Group Hospital Service, Inc. is a non-profit corporation?

A Yes.

Q All right. How did that come to be formed as a non-profit corporation?

A Well, it was formed in 1939—I'm not so sure of that date. Obviously I wasn't involved at that time.

Q Well, my question is was it formed by a group of individuals or by another insurance company or some other—

A By a group of individuals.

Q All right. Now, was this the first of the companies you mentioned here that was formed?

A Yes.

[9] Q All right. So they first formed Group Hospital Service, Inc. which is also known as Blue Cross of Texas and that is a non-profit corporation, is that correct?

A It is a non-profit hospital service corporation.

Q All right. Now, what is a hospital service corporation?

A It is the type of company organized under Chapter 20 of the Texas Insurance Code.

Q What does it do?

A It provides hospital benefits through contracts between that corporation and hospitals as well as it provides benefits for medical and surgical care on an indemnity basis.

Q Now, Group Life and Health Insurance Company, that is a profit corporation formed under the Texas Businesse Corporation Act?

(A discussion was had off the record.)

Q (By M. Pullen) Well, let's go on and I'll ask you that again when they come back.

Now, the other companies that you mentioned—well, let me ask you this; Group Life and Health Insurance

Company, is the stock in that owned by [10] various individuals or is that owned by some corporation?

A All of the stock is owned by Group Hospital Service Incorporated except for a few qualifying shares issued to members of the Board of Directors.

Q All right, sir. Do you know the reason that Group Life And Health Insurance Company was formed or what it was intended to be used for; maybe that will be a little easier?

A Again that corporation was formed prior to my association with Group Hospital Service.

Q Well, what area—

A I have an understanding of why it was but I do not know.

Q All right. Would you tell us what your understanding is?

A Well, it's my understanding that it was formed in order to permit issuance of group master contracts for coverage of physician services.

Q All right. Now, was there any other type coverage that has been added since its formation?

A Yes, we issue life insurance, disability income insurance, the drug coverage, dental coverage; a wide range of—

Q All right.

[11] A —benefits.

Q Now, the other corporations that you mentioned; we've covered Group Hospital Service, Inc. and Group Life And Health Insurance Company, what do the other corporations do?

A Well, the only other corporation is Group Medical And Surgical Service and it has issued in the past physician service benefits. Since the formation of Group Life And Health Insurance Company very little new coverage has been issued by Group Medical And Surgical Service.

Q All right.

MR. KAISER: May we go off the record for just a minute?

(A discussion was had off the record.)

Q (By Mr. Pullen) Now, does Group Hospital Service, Inc. furnish in effect the legal staff for the other subsidiary corporations?

A Yes, there is a management contract between Group Life And Health Insurance Company and Group Hospital Service.

Q Does Group Life And Health Insurance Company have any employees of its own?

A I could not actually answer that question.

[12] Q All right. May we leave a blank and would you find out and if so tell me?

A Okay. [Answer inserted later:] No.

Q How many approximately it has at this time and what general areas they work in.

Are any of the shares of stock in any of the companies that you've mentioned other than the directors qualifying shares owned by any individual stockholders?

A No.

Q So then what we have is a corporate structure that consists of Group Hospital Service, a non-profit corporation at the top and then it owns the stock of three—

A No.

Q All right. Well,—

A Group Life And Health, as I stated, is a stock company.

Q Yes.

A And Group Hospital Service does own the stock of Group Life And Health Insurance Company.

Q All right.

Excerpts from Deposition of Steve G. McDonald

A Group Medical And Surgical Service is a state-wide mutual assessment company. It is not a [13] stock company.

Q What is a state-wide mutual assessment company?

A It's a mutual company owned by the policy holders.

Q All right. And is that operated under a management contract as well by Group Hospital Service, Inc.?

A Yes, it is.

Q Now, the other company you mentioned which I think—is there a fourth company?

A No, there's just three.

Q All right. Well then, we've covered it?

A Yes.

MR. KAISER: We should have done this yesterday.

MR. PULLEN: Well, I was trying.

Q (By Mr. Pullen) Now, you mentioned the Blue Cross Association. Would you explain the relation between the Texas—what I call Blue Cross-Blue Shield Companies and the other Blue Cross-Blue Shield Companies in the United States?

A All right. Presently the Blue Cross name and service mark are owned by the Blue Cross Association.

Q Now, where is that located?

[14] A Chicago, Illinois.

Q All right.

A Group Hospital Service, Incorporated is a member of the Blue Cross Association and is authorized by the Blue Cross Association to use a Blue Cross service mark in the State of Texas.

Q All right.

A The other Blue Cross Plans across the nation are simply members of the Blue Cross Association and authorized to use the service mark.

Excerpts from Deposition of Steve G. McDonald

Q How is this membership authorized; is it through some sort of licensing agreement or a contract of some type?

A I would have to review the files on that to answer that question.

Q All right. Do the Texas companies pay a fee to the national organization of some type for the use of the name?

A There are dues.

Q Dues?

A Yes.

Q Do you have any idea what they are annually?

A No.

Q Who would know that?

A I suppose Mr. Pascasio, our Vice President [15] of Finance.

Q All right. What exactly besides the use of the name does the national association furnish to its due paying members?

A They provide assistance in handling of national accounts and they have a wire system which permits the processing of claims of a plan member who is confined or receives hospital care in another state served by another Blue Cross plan.

Q They have a legal staff?

A Yes.

Q Do they give any guidelines or rules or regulations to the companies such as the Texas companies who use their name?

A They publish advisory memorandum from time to time, yes.

Q Are you the attorney who has primary responsibility for filing of material with the Commissioner of Insurance of the State of Texas here at Blue Shield?

A I have the primary responsibility for filing policy forms with the commissioner.

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Excerpts from Deposition of Steve G. McDonald

[21] Q With relation to the prepaid prescription drug coverage does Group Life And Health Insurance Company engage in that business in any other state other than Texas?

A We only issue the coverage to corporations in Texas.

Q All right. Do you issue the coverage to any individuals in Texas?

A We do not have individual contracts.

Q With individual policyholders?

A With individual policyholders.

Q In other words, if I wanted to get this coverage I could not get it as a single individual; I would have to be an employee of some corporation?

A That is correct.

Q And are the corporations who have this coverage, are they corporations who do business in other states as well as in Texas?

A They could, yes.

Q Well, could you give me some examples of some who have the coverage who do business both in Texas and in other states?

A Ling-Tempco-Vought.

Q All right.

A And its affiliated corporations.

[22] Q All right. Mack Trucks?

A I presume so, yes. Although we did not issue this contract.

Q No, I understand. United Auto Workers Plan?

A I'm not aware that there is a United Auto Workers Plan per se.

Q Well, how about Ford Motor Company or Chrysler Corporation?

A Yes.

Q They are issued this type of coverage by Group Life And Health Insurance Company as to their Texas employees?

Excerpts from Deposition of Steve G. McDonald

A No, sir.

Q Well, how do you get involved with their employees; by you I mean your Group Life And Health Insurance Company?

A Through participating plan agreements in those instances. Those coverages are issued by the Michigan—I don't actually know whether it was issued by Michigan Blue Cross or Michigan Blue Shield but one of the Michigan plans.

Q But Group Life And Health Insurance Company services this plan for employees of those corporations who are physically in Texas?

A Yes, on behalf of that—the other plan.

* * * *

[33] Q How many filings have there been roughly as best you can approximate—policy forms which apply to drugs under hospital coverage?

A Any number I would get would be the shearest [*sic*] speculation because it goes back to 1939, policy forms have been issued since that date.

Q I'm going to hand you what has been marked as Deposition Exhibit 1 to Miss Judy Johnson's deposition which is the Participating Drug Pharmacy Agreement and ask you if that has ever been filed with the Commissioner of Insurance of the State of Texas?

A This form was filed when the Form CC-OHDS-2 was filed in 1969.

Q All right. Now, where do we have showing that that was included in the filing?

A There's reference to it in the March 14, 1969 letter from me to Mr. McAnelly.

Q All right. And that was the letter where the policy form was disapproved?

A Yes, sir.

Excerpts from Deposition of Steve G. McDonald

Q Now, in the exemption order does the exemption order refer to Deposition Exhibit 1 to Miss Judy Johnson's deposition?

[34] MR. KAISER: Counsel, the exemption order speaks for itself. There's no need for the witness to read the exemption order into the record. It's attached as an exhibit.

MR. PULLEN: I didn't ask him to read it into the record. I just asked if he sees any reference to BD-1 PGPA-1.

MR. KAISER: Counsel, why don't you read it for yourself.

MR. PULLEN: All right. I will answer it. I see no reference.

MR. KAISER: Fine. Let the record so reflect Mr. Pullen sees no reference.

Q (By Mr. Pullen) As you read the exemption order do you see anything that has reference to it?

MR. KAISER: I'll instruct the witness not to answer the question. The document is already attached as an exhibit.

Q (By Mr. Pullen) Does the State Board of Insurance to your knowledge have jurisdiction over independent pharmacies?

A Not to my knowledge.

* * * *

[46] Q (By Mr. Pullen) I'm now going to hand you Deposition Exhibit 46 which is a letter to you dated February 25th, 1969, from Richard J. Patterson and ask you to read that. You did receive that letter, did you not?

A I assume I did.

Q All right. Now, at the end of the second paragraph there is some language that says otherwise your plan would be exposed to antitrust action by the Justice

Excerpts from Deposition of Steve G. McDonald

Department. Do you know exactly what that is referring to?

MR. KAISER: Are you asking the witness to explain what the author of this document is saying?

MR. PULLEN: If he knows.

MR. KAISER: You are not required now to speculate on what he was thinking of when he wrote the letter.

MR. PULLEN: If he knows.

[47] THE WITNESS: I don't know what he was thinking. To my knowledge I never discussed this with the gentleman other than receiving the letter.

Q (By Mr. Pullen) Well, did you attempt to check that statement out to see whether in your opinion your company would be exposed to any antitrust problems?

MR. KAISER: I'm going to object to that and ask the witness not to answer it. It calls for a conclusion of law.

MR. PULLEN: I just asked him if he checked it out.

MR. KAISER: I'll let him answer whether or not he checked it out.

THE WITNESS: Yes.

Q (By Mr. Pullen) Did you write any memorandum on your investigation?

MR. KAISER: Now, you converted a checkout into an investigation. Are you talking about checking it out?

Q (By Mr. Pullen) On the checkout?

A I do not recall.

(Deposition Exhibit Number 47 was marked for identification and a Xerox copy will be attached to the deposition.)

Q (By Mr. Pullen) I'm going to hand you [48] Deposition Exhibit 47 which is a letter from you to Richard J. Patterson dated February the 12th, 1969, and ask you if that letter was sent.

A I assume it was.

Excerpts from Deposition of Steve G. McDonald

Q All right. The next to the last paragraph refers to the contract with the participating pharmacist and also mentions the use of an assignment and then the last sentence refers to a revision of our enabling statute. What did you mean by that paragraph?

MR. KAISER: You are asking what he's referring to when he uses the term enabling statute?

Q (By Mr. Pullen) Yes. What statute specifically does that refer to?

A It probably refers to both Chapter 3 and Chapter 20 of the insurance code, perhaps maybe more—I should say the Texas Insurance Code.

Q What was the problem with the enabling statute that you were concerned with?

A Well, the enabling statutes do not specifically authorize contracts with pharmacists.

Q Was that the problem you were concerned with there?

A One question we were dealing with at this time.

* * * *

[51] Q (By Mr. Pullen) All right. Mr. McDonald, do you know the reason why you have a non-profit corporation which owns all of the stock of a profit corporation and I'm specifically with reference to group—I think it's Group Hospital Service, Inc., is that the profit corporation?

A Hospital Service, Inc. is the non-profit hospital service corporation.

Q All right. The profit corporation is which one?

A Group Life And Health Insurance Company.

Q All right. Now, what is the reason for having that corporation own the stock of Group Life And Health Insurance Company which is a non-profit corporation—which is, I'm sorry, profit corporation?

Excerpts from Deposition of Steve G. McDonald

A I think we better repeat that question and be sure we've got the corporations right. I couldn't follow you.

[52] MR. PULLEN: All right. Would you repeat the question?

(The above question was read back by the Court Reporter.)

THE WITNESS: As I think I stated previously I was not associated with Group Hospital Service. Inc. at the time that Group Life And Health Insurance Company was acquired. It is my understanding that it was a policy decision. It was an investment made by the corporation.

MR. KAISER: You used the word acquired. Do you mean organized?

THE WITNESS: No, it was an existing charter that was purchased.

* * * *

[55] Q (By Mr. Pullen) Mr. McDonald, what is the reason Blue Shield went into the prepaid prescription coverage as a result of the United Auto Workers Plan for such coverage for members of that union in the State of Texas?

A To the best of my knowledge the U.A.W. Negotiated Plan For Automotive Workers was the first prescription drug program of this type.

Q All right. And is that what led Blue Cross or Blue Shield into the coverage in Texas so that they could participate?

A It commenced our consideration of it.

Q All right. That's fine.

A —of the question.

* * * *

Excerpts from Deposition of Steve G. McDonald

[57] . . . [A]ttached to the letter is a Participating Plan Agreement to which you've already testified. Would you explain to me why this document is marked filed as opposed to being marked in some other manner?

A It's marked filed because the Participating Plan Agreements are not required to be approved under the statute but are filed with the Insurance Department for informational purposes.

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DRUG SUPPLEMENT POLICY OF GROUP LIFE AND HEALTH INSURANCE COMPANY, DATED APRIL 1, 1969, DISAPPROVED BY ORDER NO. 29701 OF TEXAS COMMISSIONER OF INSURANCE, DATED JUNE 18, 1969 ("EXHIBIT 37" TO DEPOSITION OF STEVE G. McDONALD, NOVEMBER 21, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

GROUP LIFE & HEALTH

Insurance Company

[LOGO]

Dallas, Texas

has issued this

DRUG SUPPLEMENT

to the

EXPERIENCE RATED GROUP MEDICAL-SURGICAL INSURANCE POLICY

No. 123456

issued heretofore or simultaneously herewith, to

XYZ COMPANY, INC.

(therewith and herein called the Employer)

as of April 1, 1969 (herein called the supplemental policy date)

and thereby agrees to provide the additional benefits detailed herein,

[Disapproved By Order No. 29701, Jun. 18, 1969, Commissioner of Insurance, State of Texas]

all in accordance with the conditions and provisions hereof, including those set out on the following pages which are a part of this supplement as fully as if recited over the signatures hereto affixed.

This supplement becomes effective on the supplemental policy date, and is issued in consideration of the application herefor made by the Employer. It will be continued in force subject to the timely payment of premiums herefor, until terminated in accordance with the provisions of the Article captioned "Termination of Drug Coverage."

IN WITNESS WHEREOF, the Insurer has caused this supplement to be executed at its Home Office in Dallas, Texas.

President

Countersigned:

Registrar

[Disapproved By Order No. 29701, Jun. 18, 1969,
Commissioner of Insurance, State of Texas]

ARTICLE I—SUPPLEMENTAL DEFINITIONS

AS USED HEREIN:

A. GROUP HOSPITALIZATION CONTRACT means an instrument issued by Group Hospital Service, Inc. of Dallas, Texas to the Employer, bearing the same number as that appearing on the "Experience Rated Group Medical-Surgical Insurance Policy" described on the face page hereof, including any supplements thereto.

B. GROUP MEDICAL-SURGICAL INSURANCE POLICY means the "Experience Rated Group Medical-Surgical Insurance Policy" described on the face page hereof.

C. BASIC COVERAGE means the total amount of protection afforded a participant by both the group hospitalization contract and the group medical-surgical insurance policy on account of expense incurred for drugs and medicines.

D. COVERED DRUGS means any Prescription Legend Drug or injectable insulin:

(1) which is ordered by a physician;

(2) for which a written prescription order is customarily prepared;

(3) for which a separate charge is customarily made; and

(4) which is not entirely consumed at the time and place that the prescription order is written.

E. PRESCRIPTION LEGEND DRUG means any medicinal substance—the label of which, under the Federal Food, Drug, and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription."

F. DRUG DEDUCTIBLE means the amount to be paid by a participant toward the cost of the initial purchase of each covered drug and toward the cost of each refill purchase of each covered drug and for each such purchase and is equal to the amount specified in Item 20 of the schedule.

G. PRESCRIPTION ORDER means a request for medication by a physician.

H. PHARMACY means a licensed establishment where Prescription Legend Drugs are dispensed by a person who is not a practitioner of the healing arts and who is licensed to dispense such drugs under the laws of the state in which he practices.

I. PROVIDER means any pharmacy, physician, or any other person or organization legally licensed to dispense drugs.

J. PARTICIPATING PROVIDER means a provider located in the State of Texas with which the Insurer or Group Hospital Service, Inc. of Dallas, Texas, has entered into a written contract for the rendition of covered drugs for which benefits are provided by this supplement, or any provider located outside the State of Texas with which any other Blue Cross or Blue Shield Plan has entered into such a contract.

K. NON-PARTICIPATING PROVIDER means a provider who is not a participating provider.

ARTICLE II—TERMS AND PROVISIONS

A. All definitions, limitations, and provisions recited in the group medical-surgical insurance policy are hereby adopted and shall be construed to apply in like manner and with equal force to this supplement, any provisions insofar as they are in conflict with provi-

sions herein contained, in which case the provisions of this supplement shall govern in any interpretations of rights or obligations accruing hereunder.

B. It is hereby specially declared that the non-duplication provisions set forth in Article IV, Section F, of the group medical-surgical insurance policy are applicable to this supplement except insofar as they are modified by the provisions of the following subsections:

1. Determination of drug benefits under this supplement shall be made in relation to each "claim," consisting of any combination of charges for covered drugs which are incurred within a calendar year and submitted at one time by or on behalf of a participant to the Insurer at his request for payment of drug benefits applicable thereto.

2. When the non-duplication provisions are applicable, the benefits of the other coverage and all benefits provided under the basic coverage on the items composing the claim shall be deducted from the charges for all such items, and the Insurer will pay the remainder; provided, however, that in no event shall these provisions be construed to increase the amount of total benefits which would be payable under this supplement on account of such claim in the absence of other coverage.

ARTICLE III—BENEFITS

A. Subject to the exclusions, limitations, and all other terms and provisions set forth herein, any participant shall be entitled to receive covered drugs from any participating provider as a benefit hereunder and shall be required to pay no more than the drug deductible for each of such covered drugs.

B. Any participant receiving covered drugs from a non-participating provider shall be entitled to benefits equal to 75% of the result of the usual and customary charges for such covered drugs as determined by the Insurer, reduced by the drug deductible for such covered drugs; except that for covered drugs received from a non-participating provider located outside of the State of Texas, such participant shall be entitled to benefits equal to 100% of the usual and customary charges for such covered drugs, reduced by the drug deductible for each such covered drugs.

C. Payment of benefits by the Insurer to the provider or to the Employer, as the Insurer may elect, shall constitute full discharge of all responsibility of the Insurer to the employee on account of care rendered to any participant under his coverage.

ARTICLE IV—LIMITATIONS AND EXCLUSIONS

In addition to the limitations and exclusions stipulated in Article VI of the group medical-surgical insurance policy, it is provided that no drug benefit shall be available for any of the following:

A. Any charge for a contraceptive medication, even if such medication is a Prescription Legend Drug, and any charge for therapeutic devices or appliances (including but not by way of limitation, hypodermic needles, syringes, support garments, and other non-medicinal substances) regardless of their intended use.

B. Any charge for services other than Covered Drugs, including administration of a Prescription Legend Drug or injectable insulin.

C. The charge for more than a 34-day supply of a medication, except that Blue Cross-Blue Shield will cover

100 unit doses (e.g. tablet or capsule) of a natural thyroid product and 100 unit doses of nitroglycerine.

D. The charge for any prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from the physician's order.

E. Covered Drugs for which no charge is customarily made.

F. Covered Drugs to the extent that a benefit is provided therefor under the basic coverage.

ARTICLE V—TERMINATION OF DRUG COVERAGE

A. This supplement and coverage of all participants hereunder shall automatically terminate:

1. When the group medical-surgical insurance policy is terminated for any reason;
2. Upon default in payment of supplemental premiums, subject to the grace period and reinstatement provided for in the group medical-surgical insurance policy;
3. Upon cancellation of this supplement in any manner as specified in the group medical-surgical insurance policy for cancellation thereof.

B. The coverage of any participant under this supplement shall automatically terminate when his coverage under the group medical-surgical insurance policy is terminated, subject, however, to refund of supplemental premiums paid in advance, as therein provided.

C. Under no circumstances shall the Plan be obligated to notify any participant of the termination of this supplement or of his coverage hereunder.

Drug Supplement Policy Disapproved June 18, 1969

D. No conversion privilege afforded a participant under the group medical-surgical insurance policy shall be deemed to apply to this supplement.

ARTICLE VI—GENERAL PROVISIONS

A. DISCLOSURE AUTHORIZATION. In consideration of the Insurer's having waived physical examination in connection with the application herefor, the employee on behalf of himself and his covered dependents and sponsored dependents shall be deemed to have authorized any provider to make available to the Insurer information relating to all prescription orders, copies thereof and other records as needed by the Insurer.

B. The Insurer shall not be liable for any claim or demand for injuries or damage arising out of or in connection with the manufacturing, compounding, dispensing or use of any Prescription Legend Drugs or insulin, whether or not covered under this supplement.

C. The Insurer reserves the right to deny benefits for any drug prescribed or dispensed in a manner contrary to normal medical or pharmaceutical practice.

DRUG SUPPLEMENT POLICY OF GROUP LIFE AND HEALTH INSURANCE CO., DATED OCTOBER 1, 1974, APPROVED BY ORDER NO. 45511 OF TEXAS COMMISSIONER OF INSURANCE, DATED OCTOBER 1, 1974 ("EXHIBIT 39" TO DEPOSITION OF STEVE G. McDONALD, NOVEMBER 21, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

[LOGO]

GROUP LIFE & HEALTH INSURANCE CO.

(Herein called Blue Shield of Texas)

Dallas, Texas

has issued this

DRUG SUPPLEMENT

to the

EXPERIENCE RATED GROUP HOSPITALIZATION AND MEDICAL-SURGICAL CONTRACT

No. 34567

issued heretofore or simultaneously herewith, to

ABC COMPANY

(therewith and herein called the Employer)

as of October 1, 1974 (herein called the supplemental contract date)

and thereby agrees to provide the additional benefits detailed herein,

[Approved By Order No. 45511, Oct. 1, 1974, Commissioner of Insurance, State of Texas]

all in accordance with the conditions and provisions hereof, including those set out on the following pages which are a part of this supplement as fully as if recited over the signatures hereto affixed.

This supplement becomes effective on the supplemental contract date, and is issued in consideration of the application herefor made by the Employer. It will be continued in force subject to the timely payment of premiums herefor, until terminated in accordance with the provisions of the Article captioned "Termination of Drug Coverage."

IN WITNESS WHEREOF, Blue Shield of Texas has caused this supplement to be executed at its Home Office in Dallas, Texas.

/s/ Thomas Beauchamp, Jr.
President

/s/ Boone Powell
Secretary

Countersigned:

Registrar

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

ARTICLE I—SUPPLEMENTAL DEFINITIONS

AS USED HEREIN:

A. BASIC CONTRACT means the "Experience Rated Group Hospitalization and Medical-Surgical Contract" described on the face page hereof.

B. BASIC COVERAGE means the total amount of protection afforded a participant by the basic contract on account of expense incurred for drugs and medicines.

C. COVERED DRUGS means any Prescription Legend Drug or injectable insulin:

(1) which is ordered by a physician;

(2) for which a written prescription order is customarily prepared;

(3) for which a separate charge is customarily made;

(4) which is not entirely consumed at the time and place that the prescription order is written; and

(5) which is received by the participant while covered hereunder.

D. PRESCRIPTION LEGEND DRUG means any medicinal substance—the label of which, under the Federal Food, Drug, and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription."

E. DRUG DEDUCTIBLE means the amount to be paid by a participant toward the cost of the initial purchase of each covered drug and toward the cost of each refill purchase of each covered drug and for each such purchase and is equal to two dollars ($2.00).

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

F. PRESCRIPTION ORDER means a request for medication by a physician.

G. PHARMACY means a licensed establishment where Prescription Legend Drugs are dispensed by a person who is not a practitioner of the healing arts and who is licensed to dispense such drugs under the laws of the state in which he practices.

H. PROVIDER means any pharmacy, physician, or any other person or organization legally licensed to dispense drugs.

I. PARTICIPATING PROVIDER means a provider located in the State of Texas with which Blue Shield of Texas or Group Hospital Service, Inc. of Dallas, Texas, has entered into a written contract for the rendition of covered drugs for which benefits are provided by this supplement, or any provider located outside the State of Texas with which any other Blue Cross or Blue Shield Plan has entered into such a contract.

J. NON-PARTICIPATING PROVIDER means a provider who is not a participating provider.

ARTICLE II—TERMS AND PROVISIONS

A. All definitions, limitations, and provisions recited in the basic contract are hereby adopted and shall be construed to apply in like manner and with equal force to this supplement and any other provisions insofar as they are in conflict with provisions herein contained, in which case the provisions of this supplement shall govern in any interpretation of rights or obligations occuring hereunder.

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

B. It is hereby specially declared that the non-duplication provisions set forth in Article V, Section E, of the basic contract are applicable to this supplement except insofar as they are modified by the provisions of the following subsections:

1. Determination of drug benefits under this supplement shall be made in relation to each "claim," consisting of any combination of charges for covered drugs which are incurred within a calendar year and submitted at one time by or on behalf of a participant to Blue Shield of Texas at his request for payment of drug benefits applicable thereto.

2. When the non-duplication provisions are applicable, the benefits of the other coverage and all benefits provided under the basic coverage on the items composing the claim shall be deducted from the charges for all such items, and Blue Shield of Texas will pay the remainder; provided, however, that in no event shall these provisions be construed to increase the amount of total benefits which would be payable under this supplement on account of such claim in the absence of other coverage.

ARTICLE III—BENEFITS

A. Subject to the exclusions, limitations, and all other terms and provisions set forth herein, any participant shall be entitled to receive covered drugs from any participating provider as a benefit hereunder and shall be required to pay no more than the drug deductible for each of such covered drugs.

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

B. Any participant receiving covered drugs from a non-participating provider shall be entitled to benefits equal to 75% of the result of the reasonable charge for such covered drugs as determined by Blue Shield of Texas, reduced by the drug deductible for such covered drugs; except that for covered drugs received from a non-participating provider located outside of the State of Texas, such participant shall be entitled to benefits equal to 100% of the reasonable charge for such covered drugs, reduced by the drug deductible for each such covered drugs.

C. Payment of benefits by Blue Shield of Texas to the provider or to the employee, as Blue Shield of Texas may elect, shall constitute full discharge of all responsibility of Blue Shield of Texas to the employee on account of care rendered to any participant under his coverage.

ARTICLE IV—LIMITATIONS AND EXCLUSIONS

In addition to the limitations and exclusions stipulated in Article VIII of the basic contract, it is provided that no drug benefit shall be available for any of the following:

A. Any charge for a contraceptive medication, even if such medication is a Prescription Legend Drug, and any charge for therapeutic devices or appliances (including but not by way of limitation, hypodermic needles, syringes, support garments, and other non-medicinal substances) regardless of their intended use;

B. Any charge for services other than Covered Drugs, including administration of a Prescription Legend Drug or injectable insulin;

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

C. The charge for more than a 34-day supply of a medication, except that Blue Shield of Texas will cover 100 unit doses (e.g. tablet or capsule) of a natural thyroid product and 100 unit doses of nitroglycerine;

D. The charge for any prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from the physician's order;

E. Covered Drugs for which no charge is customarily made;

F. Covered Drugs to the extent that a benefit is provided therefor under the basic coverage;

G. Covered Drugs which are not medically necessary.

ARTICLE V—TERMINATION OF DRUG COVERAGE

A. This supplement and coverage of all participants hereunder shall automatically terminate:

1. When the basic contract is terminated for any reason;

2. Upon default in payment of supplemental premiums, subject to the grace period and reinstatement provided for in the basic contract;

3. Upon cancellation of this supplement in any manner as specified in the basic contract for cancellation thereof.

B. The coverage of any participant under this supplement shall automatically terminate when his coverage under the basic contract is terminated, subject, however, to refund of supplemental premiums paid in advance, as therein provided.

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

Drug Supplement Policy Approved October 1, 1974

C. Under no circumstances shall Blue Shield of Texas be obligated to notify any participant of the termination of this supplement or of his coverage hereunder.

D. No conversion privilege afforded a participant under the basic contract shall be deemed to apply to this supplement.

ARTICLE VI—GENERAL PROVISIONS

A. DISCLOSURE AUTHORIZATION. In consideration of Blue Shield of Texas having waived a physical examination in connection with the application herefor, the employee on behalf of himself and his covered dependents shall be deemed to have authorized any provider to make available to Blue Shield of Texas information relating to all prescription orders, copies thereof and other records as needed by Blue Shield of Texas.

B. Blue Shield of Texas shall not be liable for any claim or demand for injuries or damage arising out of or in connection with the manufacturing, compounding, dispensing or use of any Prescription Legend Drug or insulin, whether or not covered under this supplement.

C. Blue Shield of Texas reserves the right to deny benefits for any drug prescribed or dispensed in a manner contrary to normal medical or pharmaceutical practice.

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

EXCERPTS FROM DEPOSITION OF ALBERT W. POGUE, DECEMBER 30, 1975

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

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* * * *

[3] DIRECT EXAMINATION

Questions by Mr. Kaiser:

Q Would you state your full name, please?
A Albert W. Pogue.
Q Mr. Pogue, do you go by any nickname?
A I go by "Woody," yes.
Q Mr. Pogue, what is your residence address?
A 5605 Burrough Cove, Austin.
MR. PULLEN: How is that Burrough spelled?
A B-u-r-r-o-u-g-h (spelling).
Q Mr. Pogue, by whom are you employed?
[4] A State Board of Insurance.
Q Do you have a title, Mr. Pogue?
A Yes. I am Division Manager of the Policy Approval Division.

* * * *

[6] Q Mr. Pogue, how long have you been with the State Board of Insurance?
A Seven years.
Q What were your previous positions with the State Board?
A I was previously a policy analyst, actuarial field examiner, supervisor of the Life Policy Unit, manager of Headquarters Section, and then eventually Division Chief.
Q You said that you were a field examiner?
A Actuarial field examiner.
Q What does an actuarial field examiner do?

Excerpts From Deposition of Albert W. Pogue

A Basic duties are to check the reserve—verification on reserves for the domestic life companies in the State of Texas.

Q All right. And then you said after your period as field examiner you moved to what position?

A I moved to the supervisor of the Life Policy Unit, then I went back to the field.

[7] Q What did your duties entail as a supervisor of the Life Policy Unit?

A I was in charge of a group of analysts whose responsibilities were to approve or disapprove any life contract, annuity contract or credit life contract submitted for use in the State of Texas.

Q All right. What guidelines did you use in determining whether or not to approve or disapprove credit life contracts?

A We have the State Insurance Code, our statutes there as well as court orders, commissioners' orders and departmental regulations.

Q After your tenure as supervisor of the Life Policy Unit where did you go then?

A I went back to the field again.

Q In what capacity?

A As an actuarial examiner again.

Q And then after the period of time that you were an actuarial examiner—

A I came back in as supervisor of the Life Policy Unit for three months prior to being promoted to Headquarters Section Manager.

Q All right, sir. And then what was your next position?

A My next position was Division Chief.

Q Of the—

[8] A Policy Approval Division which is a new name under the reorganization for the old Life Division.

Q I see. Now, you referred a moment ago to the Life Policy Unit.

Excerpts From Deposition of Albert W. Pogue

A The Life Policy Unit is a section within the Life Division. The Life Division is made up of a Life Policy Unit section, a Group Life and—Group Accident and Health Section, Individual Accident and Health Section and Credit Life Section.

Q From the time you became the supervisor of the Life Policy Unit up until today have you basically or generally been in the same division of the State Board of Insurance?

A I have been in the same division of the State Board of Insurance since I went to work for them.

Q Can you tell me what year you went to work for the State Board of Insurance?

A 1969.

MR. PULLEN: I am sorry.

A 1969.

Q Can you tell me generally what your duties were as supervisor of the Life Policy Unit?

A As supervisor of the Life Policy Unit my basic duties were to supervise six analysts whose duties were to review all life contracts, annuity contracts, group annuity contracts and credit life and credit A and H contracts submitted [9] for use in the State of Texas. I myself handled all of the difficult contracts, the difficult mathematical contracts that the analysts could not, I composed all of the approval and disapproval orders for that particular unit.

Q When did you become Manager of the—or Division Manager of the Policy Approval Division of the State Board of Insurance?

A The Division Chief job or Division Manager job was effective November 1, 1975.

Q How long have you held the same responsibilities as you presently hold?

A Basically the same responsibilities that I hold now I have had since January 1, 1974.

Excerpts From Deposition of Albert W. Pogue

Q Am I to understand, Mr. Pogue, that the difference came in the reorganization of the State Board?

A Right.

Q I don't want to make a statement; I want to ask a question. Have your duties always been the same however your title changed?

A My duties since January 1, 1974, have been basically the same as they are right now other than a title change effective November 1.

Q Mr. Pogue, what are your responsibilities and your duties in your present position as Division Manager of the Policy Approval Division?

[10] A My present duties encompass the supervision of four distinct sections, the Life Policy Section, the Group Life and Group A and H Section, the Individual Accident and Health Section and Credit Life Section. My primary duties are administrative responsibilities in these areas.

Q Do you have supervisory responsibility?

A I have direct supervisory responsibility over all the people in my division, and I have four supervisors under me that head up these four different sections.

Q To whom do you report, Mr. Pogue?

A I report to the Commissioner.

Q And who is presently the Commissioner of the State Board of Insurance?

A Joseph Hawkins.

Q Just for my own information, how long has Mr. Hawkins been the Commissioner?

A I believe it was effective permanently on either September 1 or October 1, 1975, one of those two dates.

Q Was Mr. Hawkins' predecessor Mr. Joe Christy?

A No. Mr. Hawkins' predecessor was Don B. Odum.

Q Was Joe Christy at one time the Insurance Commissioner?

Excerpts From Deposition of Albert W. Pogue

A No. Joe Christy has always been the Chairman of the State Board of Insurance.

Q I understand. Does the State Board of Insurance consist of more than one Commissioner?

[11] A The State Board of Insurance has one Commissioner and a three-member Board. The Commissioner answers to the three-member Board.

Q Does the Commissioner have any authority over the Board per se? Can he reverse a decision of the Board or overrule a decision of the Board?

A Right the opposite. The Board can overrule a decision of the Commissioner.

Q Mr. Pogue, were you served with a subpoena duces tecum to appear at this deposition?

A Yes, I was.

Q Have you brought the documents specified in the subpoena?

A Yes, I have.

Q May I see them, please?

MR. KAISER: Let's go off the record.

(There was a discussion off the record.)

Q Mr. Pogue, are you the custodian of the records maintained in the Policy Approval Division of the State Board of Insurance?

A Yes, I am responsible for the records.

Q Are the records maintained in the Policy Approval Division of the State Board of Insurance kept under your supervision and control?

A Yes, they are until such time as we have accumulated records for ten years, and then we send the contracts over [12] to Archives which are still in my control because I have got a log on them. I can call for them at any time. Correspondence we keep for two years, and then we send it to Archives, and again it is logged and in my control.

Excerpts From Deposition of Albert W. Pogue

Q Mr. Pogue, I am going to hand you now—
MR. KAISER: Off the record.

(There was a discussion off the record.)

MR. KAISER: We stipulate to the introduction of Xerox copies in lieu of the originals.
MR. CHURCH: Which the witness has identified.
Q Mr. Pogue, I am going to hand you Deposition Exhibits 51 through 62, inclusive, and these documents have been marked this morning. I would ask you to look at them, sir, and tell me if those are a part of the documents which you have brought—or those are documents which you have brought pursuant to the subpoena duces tecum.
A Yes, they are exact copies of my original files.
Q Mr. Pogue, do the documents which you are presently holding in your hand which are marked as Deposition Exhibits 51 through 62, inclusive, constitute a part of the official records of the State Board of Insurance?
A They do.
Q Mr. Pogue, would you explain for me, please, the function of the Approval Division of the State Board of Insurance?
A Our responsibility is to review all contracts of individual [13] life and individual annuities, group annuities, variable annuities, both individual and group, group A and H contracts, group life contracts, combination group accident, health and life contracts, blanket accident and health contracts, credit life contracts, accident and health contracts, individual accident and health contracts that are to be sold or issued or sold to be issued for delivery in the State of Texas.
Q With a view toward doing what do you review these contracts?
A We review these contracts to make sure that they comply with statutory requirements as set forth in the

Excerpts From Deposition of Albert W. Pogue

Insurance Code or that they comply with rules and regulations promulgated by the Board or by the Commissioner.
Q Mr. Pogue, are you familiar with the insurance business transacted by Group Life and Health Insurance Company which is also known as Blue Shield of Texas?
A Yes.
Q What is a Chapter 3 insurance company, Mr. Pogue?
A A Chapter 3 insurance company is a stock life company.
Q Do you know how Chapter 3 companies are formed?
A Chapter 3 companies can be formed when they come in and request a charter, put up the minimum capital and surplus of $200,000.00.

* * * *

[16] Q Mr. Pogue, when you say 3.53 are you referring to Article 3.53 of the Insurance Code?
A I am referring to Article 3.53 of the Texas Insurance Code.
Q To your knowledge, Mr. Pogue, is Blue Shield a Chapter 3 company?
A To my knowledge, Group Life and Health is a Chapter 3 company.
Q All right, sir. To your knowledge is Group Life and Health Insurance Company a domestic insurance company?
A It is a domestic insurance company of the State of Texas.
Q To your knowledge, Mr. Pogue, what kind of insurance coverage is Blue Shield authorized by the State Board of Insurance to issue?
A Group Life and Health is authorized to issue life and health coverage.
Q May we also say group coverage included?
A Group life and group accident and health coverage.
Q Mr. Pogue, are Chapter 3 companies required to submit anything to the State Board of Insurance prior to

issuing a new policy of insurance in the State of Texas?

A A Chapter 3 company operating in the State of Texas is required to submit all policy contracts which they propose to market to the citizens of the State of Texas for [17] approval prior to the issuance of these contracts.

Q May a Chapter 3 company—and again I am referring only to domestic Chapter 3 companies—may a Chapter 3 company issue a new policy in the State of Texas without submitting it first to the State Board of Insurance?

A They may do it, but if they do it they are violating Texas law.

Q I understand. A moment ago you said that a domestic Chapter 3 company was required to submit all proposed policy forms—

A Correct.

Q —to the State Board of Insurance?

A Right.

Q What is the source of that requirement, Mr. Pogue?

A Our State Insurance Code.

Q Do you know any specific provision of the Code?

A Article 3.42.

Q After submission of a new policy of insurance or a new form of policy of insurance, what action may the State Board then take with respect to the policy?

A The Board may—the Commissioner may approve or disapprove the contract.

Q Does he have any other alternatives? When I say "he" I mean the Commissioner.

A The Code gives the Commissioner of Insurance a wide parallel of powers. The Code also exempts certain companies from [18] approval of contracts. The Commissioner upon his discretion can deviate from the Code as long as he does not take upon himself a legislative responsibility.

Q Now, I believe you said that the Code exempts certain policies of insurance. Is it not correct to say that the Code gives the Commissioner authority to exempt certain policies of insurance?

A The Commissioner's duties are to carry out the requirements of the statutory legislative directives of the Code, and the Code itself does exempt certain organizations from filing contracts, and if the Commissioner then exempts an organization from filing the contract it is set forth by statute. He is merely carrying out the directives of the Legislature.

Q Mr. Pogue, if a proposed policy that is filed with the State Board of Insurance is disapproved, does the Commissioner then have statutory or regulatory authority to issue an exemption for that policy?

A If a contract is disapproved on the division level, the company which had the contract disapproved has the right to appeal to the Commmissioner for a change in his opinion or ruling on the contract. If the Commissioner deems that an error was made in the disapproval of the contract he can reverse the decision. If he deems that he was correct, then the party has the right to appeal to the State Board [19] of Insurance the Commissioner's decision. If the Board then deems that the Commissioner was right, they will uphold it, and the next step is the courthouse.

Q Let's talk a little bit more about exemptions. Mr. Pogue, are you familiar with Article 3.42 of the Insurance Code?

A Yes.

Q Do you use that Article and does the Approval Division of the State Board of Insurance use that Article in its day-to-day activities of regulating and governing the insurance business?

A Article 3.42 is the statute within the Code which gives the State Board of Insurance the right to approve or disapprove a contract.

Q All right. Let me hand you Article 3.42, and I will ask you to look at Subparagraph E if you would, please, sir.

MR. CHURCH: Off the record.

(There was a discussion off the record.)

Q Mr. Pogue, in 1969 did the Board of Insurance Commissioners have authority to issue exemptions to certain policies of insurance pursuant to Article 3.42 of the Insurance Code, 3.42-E?

A Article 3.42-E gives the Commissioner the right—and when we are talking about the Board of Insurance Commissioners in here we are talking about the Commissioner of Insurance.

Q All right, sir.

[20] A —the right to exempt from the approval requirements under 3.42 certain documents or contracts if in his wisdom he deems it is not necessary for approval for the protection of the public of the State of Texas.

Q Now, is this one of the regulatory powers of the Commissioner of Insurance?

A That's right.

Q Mr. Pogue, can you tell me what statutory or regulatory requirements there are that govern the decision of the Board or the Commissioner of Insurance to approve, disapprove or exempt a policy?

A Rephrase that, please.

Q Are there any statutory or regulatory requirements that govern the decision of the Board or the Commissioner of Insurance in determining whether or not to disapprove, approve or exempt a policy of insurance?

A Statutory requirements, I would say none, that I know of, other than Article 3.42-E gives the Commissioner the right if in his opinion it does not require approval.

Q Tell me, in determining whether or not to approve or disapprove, whatever you are going to do to a policy,

what statutory or regulatory authority you refer to as your—for guidance.

A I refer to whether I am going to approve in my Division, or disapprove a contract, I refer to the specific portion [21] of the Code in which it applies. Article 3.42 gives us the right to approve or disapprove virtually every type of contract that is utilized in Texas by virtually every type company that operates in Texas, and there are portions of the Code directed at these specific types of contracts, and if it is determined that they meet the statutory requirements set forth in the Code or rules and regulations promulgated by the Board, then a decision is made to approve or disapprove them.

Q All right, sir. Let's assume that a Chapter 3 company files a policy form for approval. Where do you then go to get your statutory or regulatory guidance in determining whether or not to approve the policy?

A Again it boils down to what type contract we are talking about.

Q Let's say it is a life, health and accident policy.

A If we are talking about a life contract we look to Article 3.42 which gives us the right to review the contract, and then Article 3.44 and 3.44-A set out the requirements for the contents of a life contract, individual life contract. Article 3.70 sets out the requirements for the individual life, accident and health contract. Article 3.50 sets out the requirements for a group life contract, and very few articles in the Code can be utilized in the approval of a group accident and health contract. Article 3.42 is our [22] strongest.

Q After being reviewed by the State Board of Insurance, will the action of the State Board ultimately take the form of an official order of the Commissioner of Insurance?

A After being reviewed by the appropriate division within the Board, any formal action taken on a form,

whether it is approved or whether it is disapproved, is done so over the signature of the Commissioner of Insurance.

Q Would that also apply to an exemption?

A It would apply to an exemption on the Commissioner's level, yes.

Q Is the Commissioner the only person at the State Board that can grant an exemption?

A The Commissioner's responsibility at the State Board is to approve or disapprove, or if, in his wisdom, exempt contracts. He is the one responsible for the approval of these contracts.

Q If a new policy form is disapproved by the State Board, what may the submitting insurance company then do with that policy form?

A They may come back to the State Board to the Policy Approval Division, sit down and try to work it out with the supervisors in charge of the particular section, or the analyst, and try to bring it into conformity with the State statutes. In the event that the company feels strongly that they have [23] not violated the statute, and the department on the division level feels that they have violated the statute, then the company has the right to appeal to the Commissioner for a formal hearing on it. The Commissioner will hear both sides of the problem, both staff and company, then after ten days—he will keep his record open for further evidence. At the end of ten days the Commissioner will review the context of the hearing and will make a decision whether or not he feels that the staff made a proper decision on it. Then in the event that he deems that the staff had, he upholds the staff's order and will cut an order saying that the form is still disapproved. In the event that he feels that the staff made a mistake, he will reverse the decision of his order and approve the contract.

A All right, sir. Mr. Pogue, if a policy form is disapproved, may the submitting company then issue the policy?

A If a contract is disapproved and the company issues the contract while it is still in a disapproval status, they have violated State laws.

Q Are there certain penalties prescribed in the Insurance Code for insurance companies who violate the State law?

A There are penalties prescribed. I believe the section of the Code provides for a maximum fine of up to $5,000.00.

• • • •

[25] Q If a new policy form is approved by the State Board, is an order also issued to that effect?

A Yes, they are.

Q After approval of a policy form what may the insurance company then do with that policy?

A The insurance company may solicit business under that contract.

Q Can we say that it is authorized to issue that contract of insurance in the State of Texas?

A It is authorized to issue that contract in the State of Texas subject to the provisions under which it was approved.

Q After approval of a particular policy form, is the submitting insurance company then subject to the continuing regulation and control of the State Board with respect to that policy of insurance?

A Yes, they are. In the event that that contract is changed in any way contentwise, benefitwise, the contract must be resubmitted to the Board under a different form number for reapproval prior to continued use of it. Also there is a continuous monitoring of the use of the

contract through our Claims Section and also through our Examination Section.

* * * *

[28] Q If a new policy form is exempted from the requirements of Article 3.42 by the Commissioner, is an order issued to that effect?

A If there is a contract exempted from approval status, there would be an exemption order cut by the Commissioner.

Q After exemption of a contract, what may the insurance company then do with the policy upon which it has received an exemption?

A If the Commissioner deems that a contract does not need approval and exempts it from the requirements set forth in Article 3.42, the company can utilize the contract or instrument in the same manner as if it had been approved under Article 3.42.

[29] Q After exemption of a policy form, is the insurance company subject to the continuing regulation and control of the State Board with respect to that particular exempted policy?

A Yes, they would be because if a contract—if the Commissioner deems a contract does not need approval under Article 3.42, that does not necessarily mean that the Commissioner has waived the monitoring of the contract and the use of the contract in the State of Texas.

Q May the exemption be withdrawn at any particular time?

A The exemption could be withdrawn in the same manner as an approval could be withdrawn.

Q Can you tell me for what reasons an exemption could be withdrawn?

A The reasons that an exemption could be withdrawn, if it was shown that a contract which the Commissioner exempted was being—contained any unfair, inequitable, misleading, deceptive provisions, was contrary to the law

or public policy of the State in any manner, or if it again was being abused or misused in the solicitation of the contract, if the contract could be shown to be hazardous to the solvency of the company or if the contract could be shown not to be in the best interest of the public of the State of Texas.

Q All right, sir. After an exemption has been granted, are exempt policy forms subject to the same statutory requirements as approved policy forms?

[30] A After a contract has been exempted from the requirements of Article 3.42 as being approved, it does not necessarily exempt the contract from the reserve requirements, et cetera, and so on, in the Code. If there is a specific reserve requirement to be maintained on a contract, whether it is exempt or not, the reserves are going to have to be maintained on that particular contract, and it will be under the constant monitoring of the Board to make sure that the reserves are maintained on the contract, and that can be verified by the year-end annual statement, and again in the three-year physical examination that goes into a company.

Q Mr. Pogue, from a practical standpoint, does the exemption of a policy form have the same effect as approval? I am talking about a practical standpoint to the insurance company.

A All right. From a practical standpoint from the insurance company, if the insurance company receives an exemption order signed by the Commissioner of Insurance of the State of Texas for any particular contract, they utilize that contract then in the same manner as they would have utilized it had it been—received an order approving this contract under Article 3.42 specifically by some appropriate Commissioner's order number.

Q All right, sir. Mr. Pogue, after receiving an exemption, [31] are exempt policy forms treated any differently than approved policy forms with respect to the issuance

of policies by the insurance company and supervision by the State Board?

A The issuance of an exempt contract by a company would be no different than issuing an approved contract by the company. We at the Board expect them to utilize the contract in a manner consistent with State law.

Q All right, sir. From a practical standpoint at the State Board of Insurance, are exempt policies treated the same as approved policies? I am talking about after the exemption has been granted or after the approval has been granted.

MR. PULLEN: I object to that question in that I don't understand the question. Can you specify in what respect, Keith, they are treated the same?

MR. KAISER: In all regulatory respects.

A Repeat that again, please.

Q From a practical standpoint does the insurance—

MR. KAISER: Strike that.

Q From a practical standpoint does the State Board of Insurance treat exempted policies in the same manner that they would treat an approved policy, and by that I mean insofar as the State Board of Insurance's regulatory functions are concerned?

A As far as our regulatory functions on any contract issued [32] by a licensed carrier or an entity in the State of Texas we would treat an approved specimen and an exempt specimen alike.

Q Mr. Pogue, is Blue Shield currently authorized to issue—

MR. KAISER: Strike that.

Q Is Blue Shield currently authorized by the State Board of Insurance to issue a prepaid prescription drug supplement such as the ones I am handing you which have been marked Deposition Exhibit 59 and Deposition Exhibit 60?

A These instruments here are currently on file with the State Board of Insurance by Group Life and Health and are authorized to be used under an exemption order that was cut in 1969. I believe it was 1969.

Q Mr. Pogue, may I see the file that you brought with you this morning containing everything that is in the drug supplement file of Group Life and Health Insurance Company?

(Documents were handed to Mr. Kaiser.)

MR. KAISER: Thank you.

Q Mr. Pogue, are you familiar with Article 21.21 of the Insurance Code which deals with unfair competition and unfair practices in the insurance business?

A Yes, I am familiar with that portion of the Code.

Q In determining whether or not to approve or disapprove a policy form, does the Approval Division of the State Board of Insurance take into consideration the provisions of [33] Article 21.21 of the Insurance Code?

A A Chapter 3 company would fall under the provisions of Article 21.21 of the Code.

Q Well, let me ask my question again. In determining whether or not to approve or disapprove a policy, would the Approval Division of the State Board of Insurance consider the policy form in the light of Article 21.21 of the Insurance Code?

A Yes, they would.

Q To your knowledge, Mr. Pogue, is Article 21.21 one of the regulatory statutes utilized by the Commissioner of Insurance and the State Board of Insurance in performing their functions?

A Yes, it is.

Q Do the State Board of Insurance and the Commissioner of Insurance consider the provisions of that statute in determining whether to approve or disapprove or exempt a policy form?

A Yes. It can play a major role, yes.

Q Are approved policy forms subject to the provisions of Article 21.21?

A Yes.

Q Are exempt policy forms subject to the provisions of Article 21.21?

A Well, if the exemption order exempts it from approval under [34] Article 3.42, in my own opinion, they would still be subject to 21.21 of the Code.

Q Are you familiar with the provisions of Article 21.21-2 of the Insurance Code which is known as the Unfair Claims Settlement Act?

A I am not as familiar with that as our Claims Section would be, no.

Q Can you tell me whether or not approved policy forms are subject to the provisions of Article 21.21-2?

A If it could be shown that a contract was being abused in its claim settlements, then, yes, it would be subject to 21.21-2.

Q Are exempt policy forms subject to the provisions of Article 21.21-2 of the Insurance Code?

A If it could be shown that an exempt contract was abusing the exemption under which it was approved—was exempted—I don't mean the word "approved"—then—and that there was unfair claims settlements involved, then the exemption could be withdrawn, so I would say, yes, it would be subject to that section of the Code.

* * * *

[44] Q And that form was disapproved; is that correct?

A Yes, it was.

Q Now, it refers to a Form CC-OHDS-2 which I believe is Deposition Exhibit 52. Is that correct?

A Yes.

Q Do you know why that was disapproved?

MR. KAISER: Objection. There was formal action taken by the State Board of Insurance which is reflected

in the form of an official order, and that document speaks for itself.

MR. CHURCH: I think he can answer. If he doesn't know, he doesn't know.

Q Do you know why it was disapproved?

A I was not—at that time in 1969, I was not involved with this contract.

Q Well, subsequent to 1969 have you found out why Deposition Exhibit 51 and the form it referred to, which is Deposition Exhibit 52, was disapproved?

A I have reviewed Commissioner's Order Number 29701.

Q Why was it, if you know, again, disapproved?

A The reasons set forth in Commissioner's Order Number 29701 referred to the form as being in violation of 21.21 of the Texas Insurance Code. Order 29701 further stipulates that the provisions of the form violate the antitrust and [45] monopoly statutes of the State.

Q Now, subsequent to that I believe there was an exemption order issued, which is Deposition Exhibit 55.

MR. CHURCH: His original exhibits are not numbered. You will have to give it to him if you want him to look at it.

Q Do you know why the disapproval was changed to an exemption order?

MR. KAISER: The document speaks for itself.

A Am I to answer that?

MR. PULLEN: Yes.

A The order, Commissioner's exemption order, states that the contract was exempt from approval under Article 3.42 so that the Texas domestic company could have the same rights for competitive sale of these as a foreign company.

Q Are there any written guidelines at all setting out the conditions under which exemption orders will be issued with respect to a policy form?

A To particular forms, you mean?

Excerpts From Deposition of Albert W. Pogue

Q Yes.

A None that I know of, no.

Q Then is it a fair statement to say that it is a matter that is fully within the discretion of the State Board of Insurance and its personnel?

A It could be said that it is a matter that can be done if [46] shown in the discretion of the Commissioner that it is in the best interest of the public of the State of Texas.

Q Do you know what factors go into that consideration of what is in the best interest of the public?

MR. KAISER: I think you are asking him to delve into the mind of the Commissioner.

MR. PULLEN: I am asking him if he knows what factors.

MR. CHURCH: If he doesn't know, all he can say is that he doesn't know.

A If it does not violate flagrantly any of the statutes of the Texas Insurance Code, does not violate any of the rules and regulations promulgated by the Board or Commissioner, I think would be factors which would be looked at. That is the best answer I could give.

Q Let me ask you this, Mr. Pogue. I believe you previously testified that in your opinion an exemption order for all practical purposes is the same as an approval of the policy form. Is that correct, what I just said?

A When we used the word "practical," I think the word "practical" was defined to be in terms of the company's using it, and I said for all practical purposes a company would utilize an exempt form in the manner they would utilize an approved form.

* * * *

[52] A All right. Prior to our last Legislature we had what we usually use loosely the term hybrid HMO's attempting to operate in the State. Our last Legislature

Excerpts From Deposition of Albert W. Pogue

gave us the full HMO bill. Contracts of this type here which might be used with a 4509-A or any type organization like that, we were going to approve them, put them on order, and on a limited use order, and that is what this is here, that if we approved a group contract of this type to be used with this hybrid type situation that we would approve it to be extended only for use as the insurer portion of a group comprehensive medical care plan, and it cannot be used for any other purpose, and that is what this contract—

Q Would that approval apply to a plan say that has been in existence for the United Auto Workers providing for prepaid prescription coverage?

A I do not understand your question.

Q In other words, I guess what I really am saying is that this approval is strictly with regard to the HMO type plan; is that correct?

A Hybrid type HMO plan.

Q What is a hybrid type HMO plan?

A Well, the difference between a true HMO and an HMO that is funded mainly by an insurance company—there is quite a bit of difference there.

Q What is the difference?

[53] A Because an HMO is not insurance. The bill tells us that. So we do not look at an HMO as insurance nor as an entity of insurance. Now, if there is a carrier, an entity, a licensed carrier involved such as there was in this one here, then even though they use the loose term HMO, it has been funded primarily by an entity which is a life company, life insurance company.

Q Does the State Board of Insurance have any jurisdiction over independent pharmacists in the State of Texas?

A That is outside of our regulatory control.

Q So would your answer be that there is no jurisdiction as far as you know?

MR. KAISER: You are only required to answer to the best of your knowledge.

A To the best of my knowledge, I know of no statutory jurisdiction over a pharmacy.

Q If an insurance company contracts with a pharmacist, would that contract, to the best of your knowledge, be subject to the jurisdiction and regulatory authority of the State Board of Insurance?

MR. KAISER: I am going to object to the question. It calls for a conclusion of law outside the scope of this man's knowledge.

MR. CHURCH: In the deposition he can either say he does or doesn't know.

[54] MR. KAISER: I understand.

MR. CHURCH: The objection will be at the time either he is going to use them at the trial or not going to use them. Objections mean nothing in the Federal Court. The man can say if he knows or doesn't know.

A That is something I do not know.

Q All right.

A I would hesitate to say.

MR. PULLEN: Are we going to use the same numbers that we used previously on these, Keith?

MR. KAISER: Sure.

Q I am going to hand you what has been already marked as Deposition Exhibit 6 which I believe is to the deposition of Judy Johnson who is an employee of Blue Shield, and ask you to look at that.

A All right.

Q Is that document something that would be subject to the regulatory authority of the State Board of Insurance, to your knowledge?

A To my knowledge, this instrument here would constitute a contract between an entity and a pharmacy for the furnishing of services, and to my knowledge, would only make up a part of a plan of operation of one of

these organizations and would not be a part of the group contract which would require approval.

[55] Q To your knowledge, has the State Board of Insurance ever approved Deposition Exhibit 6 or any similar document?

A To my knowledge, no, we have not.

Q To your knowledge, has this document ever been submitted to the State Board of Insurance for approval?

MR. KAISER: Just a moment. To refresh the witness' recollection I will hand him an exhibit that he might want to refer to. The document I am handing you is attached to Deposition Exhibit 52 which has been identified as coming from the official files of the State Board of Insurance.

A All right.

MR. PULLEN: What was my question?

(The reporter thereupon read aloud as follows:)

"Q To your knowledge, has this document ever been submitted to the State Board of Insurance for approval?"

A The form that you are referring to and I just looked at was submitted attached to Form CC-OHDS-2.

Q Was it approved?

A The form in question—the entire contract was disapproved on Order Number 29701.

Q Was that ever changed?

A The exemption order, I think, eventually resulted in the reversal of the disapproval order in the sense that it exempted this form that we just mentioned from approval.

[56] Q Well, so that the record will be clear, is it your understanding that the State Board of Insurance under the regulatory authority granted it under the Texas Insurance Code has authority to regulate contracts between a company such as Blue Shield and an independent pharmacy?

Excerpts From Deposition of Albert W. Pogue

A My own personal opinion is that this particular contract that you just showed me—

Q You are talking about Deposition Exhibit 6?

A Right. Would be a contract between an entity and a provider which would not be a part of the original or full contract of insurance. The contract would be filed with us for informational purposes which would be a part of a plan of operations, but when we get an entire plan of operations in there are certain aspects of it that we file, certain aspects of it that we approve.

MR. KAISER: That is your opinion?

A That is my opinion.

Q Who else would be able to give an opinion on this in the State Board of Insurance?

A Our legal counsel would be the best advice.

Q Who is that right now?

A Hector De Leon.

* * * *

[58] (The reporter thereupon read aloud as follows:)

"Q Would it be a fair statement to say that as far as the regulatory authority of the State Board of Insurance, it is limited to—and again I am speaking very generally, and as you know—if you don't know it now you are going to know it when I am finished—I am not an expert in this field—basically applied to matters relating to the operations, internal operations, of insurance companies in the State of Texas and to dealings between the company and their policyholders?"

A The primary responsibilities of the State Board of Insurance is that of a regulatory agency to regulate the insurance industry within the State of Texas.

Q To your knowledge, does the State Board of Insurance regulate independent pharmacies in any manner?

A To my knowledge, the State Board of Insurance is not impounded or thrust upon us by the Legislature to regulate pharmaceutical operations.

Excerpts From Deposition of Albert W. Pogue

Q If pharmacies should enter into contracts with insurance [59] companies such as Blue Shield, in your opinion, is that contract subject to regulation by the State Board of Insurance?

A That is a matter that I think would have to be determined by our legal counsel.

Q Do you have any opinion on it?

A My personal opinion—

MR. KAISER: As opposed to a professional opinion.

A In my personal opinion I do not feel that it is a contract that would require approval of the State Board of Insurance.

Q Could you give me some examples, Mr. Pogue, of any areas of regulation which involve contracts between an insurance company and a non-policyholder?

A Would you make your question a little clearer?

Q All right. For example, is it your understanding that the State Board of Insurance has regulatory authority over all contracts of insurance companies?

A It is my opinion that the State Board of Insurance has regulatory authority over any insurance contract that the Texas Insurance Code dictates to us that we do.

* * * *

[61] Q Looking at Deposition Exhibit 6 again which is the participating drug pharmacy agreement—

MR. CHURCH: It has got different things on it and everything else.

Q To the best of your knowledge would the charge to be paid by the insured to the pharmacist as, I believe, a dispensing fee or deductible, affect the rates which Blue Shield would charge or its portion of the amount to be paid?

MR. KAISER: Objection. I don't understand the question.

MR. CHURCH: I couldn't understand it myself. I mean he might be an expert, but I can't understand the

question. Are you asking about something in the contract that is evident? I will stipulate it if the contract says it.

Q This contract, which is Deposition Exhibit 6 to the Judy Johnson deposition, provides for payment to the pharmacist of a professional dispensing fee of two dollars, and that is paid by the customer, not by Blue Shield.

A That is a copayment or deductible is the way I would interpret it.

[62] Q Right.

A And it is fairly knowledgeable in the insurance field, and anyone that would stop and think and use some common sense would know that if there is a deductible involved that the rates charged for the coverage are usually less than if there were no deductible involved.

Q Well, if this contract provided that the—or the Blue Shield contract with its policyholder for prepaid prescription coverage provided that Blue Shield would pay all but two dollars, would that make a difference as far as Blue Shield's premium was concerned or its portion of the coverage?

MR. KAISER: I think you are asking him to look into Blue Shield's business. I don't think he has testified he has any expertise in that.

MR. CHURCH: If he knows.

A I am going to merely speak from a personal opinion.

Q That is all we can ask you.

A My personal opinion, again I repeat, any time there is a deductible involved it is usually rational to think that the deductible has been taken into account in determining the premium structure so the premium structure without one would be higher usually than one with one. That is just overall.

* * * *

[65] REDIRECT EXAMINATION

Questions by Mr. Shaddox:

Q Who prescribes the regulatory authority in the State Board of Insurance?

A The Legislature.

Q Is that codified? Is that written authorization?

A The only way that we have a law in our Code Book is a law that is enacted by the Legislature.

Q What statute or rules or regulations govern the State Board of Insurance when prescribed by the Legislature?

A Our Texas Insurance Code.

Q If a contract encompasses insurance coverage, does the State Board then regulate those aspects of the contract?

A We would regulate the aspects of insurance.

Q That would be whether or not the contract was with a druggist or farmer or anyone else in the event that the contract encompassed insurance coverage, it is regulated by your department, would you then have regulatory authority over it?

[66] A The Legislature gives us regulatory authority over anything that encompasses insurance in the State of Texas.

Q All right, sir. And the State Board regulates all general aspects of insurance companies such as Blue Shield, do they not?

A We do.

MR. PULLEN: Just a minute. Read that back.

(The reporter thereupon read aloud as follows:)

"Q All right, sir. And the State Board regulates all general aspects of insurance companies such as Blue Shield, do they not?

"A We do."

A If there is an insurance function involved, then the State Board would be in a regulatory position on the case.

Q And you stated earlier that the State Board doesn't regulate rates per se on accident and health contracts, I believe, did you not?

A We do not.

Q Now, what if the solvency or well-being of the company writing the contract was involved, then the powers given to the Insurance Commission would then allow them to regulate that, would they not?

A There is nothing in the Code, to the best of my knowledge, that gives us the right to promulgate any type of rate for a life contract or an accident and health contract.

* * * *

[68] REDIRECT EXAMINATION

Questions by Mr. Kaiser:

Q I am going to hand you what has been marked as Deposition Exhibit Number 55.

A All right.

Q Which is the exemption order. I will ask you, sir, is the exemption order effective today?

A The exemption order was effective September 30, 1969, and has been effective from that date forward.

Q Has this exemption order which is marked Deposition Exhibit 55 been effective since September 30, 1969, up to today?

A Yes.

Q Mr. Pogue, I am going to hand you what has previously been marked as Deposition Exhibit Number 61 which is an official order of the Commissioner of Insurance dated October 1, 1974. I will ask you, sir, has that order been effective from October 1, 1974, up to today?

[69] A As far as I know, this order—there has been no official action taken to reverse this order. The only action that I know of being taken on it was verbal notification that there was a clerical mistake made at the State Board of Insurance and acknowledged by the entity here involved that they realized that there was a mistake made on the contract.

Q All right, sir. Mr. Pogue, you previously testified that the State Board of Insurance has regulatory authority over the business of insurance conducted within the State of Texas. Is that correct?

A Yes.

Q If it were determined by the Commissioner of Insurance that a drug service contract such as the one you have been looking at here this morning with a participating pharmacist did constitute the business of insurance, would the State Board of Insurance have regulatory authority then?

A If we deemed that the use of any type contract did constitute the business of insurance, then the State Board of Insurance would look at it from a regulatory—

MR. KAISER: Thank you. I have no further questions.

* * * *

PARTICIPATING DRUG PHARMACY AGREEMENT BETWEEN GROUP LIFE AND HEALTH INSURANCE COMPANY AND DRUG MART PHARMACY, DATED OCTOBER 12, 1974 ("EXHIBIT G" TO DEPOSITION OF ALBERT W. POGUE, DECEMBER 30, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

PARTICIPATING DRUG PHARMACY AGREEMENT

between

GROUP LIFE & HEALTH INSURANCE COMPANY

(Herein called Blue Shield)

Dallas, Texas

and

DRUG MART PHARMACY

(Herein called the Participating Pharmacy)

RETAIL PHARMACY

(Type of Organization)

12730 Nacogdoches Road, San Antonio, Texas 78217

(Address)

Pharmacy Permit No. 1352

1. The Participating Pharmacy agrees that all pharmacists dispensing drugs in its behalf are to be considered participating pharmacists. The pharmacists currently employed by the Participating Pharmacy are:

Participating Drug Pharmacy Agreement (Drug Mart)

Name	License No.
Whitnol H. Gibson	11015 Texas

2. Blue Shield agrees to provide the Participating Pharmacy with a manual which will stipulate the drugs for which benefits are available and drug deductible applicable to each person to whom drugs are to be dispensed under Section 3 of this agreement, and in which identification codes for certain of the drugs for which benefits are provided will be stipulated. Blue Shield agrees to provide the participating pharmacy with claim forms for payment in accordance with Section 3 of this participating agreement. The Participating Pharmacy agrees to complete all information required on the claim form, to retain a copy as a permanent record and to submit the original to Blue Shield.

3. The Participating Pharmacy shall dispense drugs to Subscribers who are covered under prescription drug expense contracts underwritten by Blue Shield, in accordance with the terms of such contracts as described in the Texas Blue Shield Pharmacy Manual at the time of service.

4. The Subscriber will pay to the Participating Pharmacy for each dispensed drug an amount not to exceed the required drug deductible stated in the manual for his group at the time the drug is dispensed. Except for dispensed drugs whose usual and customary charge is less than the drug deductible for the participant's

group as stated in the manual, Blue Shield agrees to pay, for each drug provided under Section 3, above, of this agreement, an amount equal to the total of the acquisition cost for such drug plus a professional dispensing fee of $2.00 less the applicable deductible. Except for dispensed drugs whose usual and customary charge is less than the drug deductible for the participant's group stated in the manual, the Participating Pharmacy agrees to accept as full payment for each drug provided under Section 3, above, of this agreement, an amount equal to the total of the acquisition cost for such drug plus the professional dispensing fee of $2.00.

Acquisition cost shall be the actual invoice cost to the Participating Pharmacy or to the company, organization or its affiliates with which the Participating Pharmacy is associated, whichever is less. Actual invoice cost shall include and reflect, with the exception of cash discounts, all trade and quantity discounts, rebates and price concessions, if any, granted by the supplier, wholesaler, or manufacturer to the Participating Pharmacy or to the company or organization with whom the Participating Pharmacy is associated.

5. The Participating Pharmacy agrees to maintain all business records suporting its acquisition cost of all drugs. The Participating Pharmacy agrees that Blue Shield shall have the right to inspect all claims forms and record of purchase necessary to establish compliance with this agreement at any time during regular business hours. The Participating Pharmacy agrees to furnish Blue Shield within fifteen (15) days, after the date of receipt of a written request from Blue Shield, with a copy of the drug purchase invoice showing the acquisition cost to the Participating Pharmacy as hereinabove computed.

6. The Participating Pharmacy shall perform all professional and other services under this agreement as an

independent contractor and shall be free to exercise its own judgment on all questions of professional practice. Blue Shield is the underwriter of the insurance protection only. The Participating Pharmacy shall not be liable for any claim, injury, demand or judgment based upon contract, tort or other grounds (including warranty or merchantability) arising out of the sale, compounding, dispensing, manufacturing or use of any prescription drug service dispensed by the Participating Pharmacy pursuant to this agreement.

7. The Participating Pharmacy agrees not to engage in any advertising relative to Blue Shield prescription drug expense contracts without prior approval of Blue Shield.

8. This agreement may be terminated at any time by either party by giving at least fifteen (15) days prior written notice to the other party.

GROUP LIFE & HEALTH
INSURANCE COMPANY

Dated at Dallas, Texas this
16 day of Oct., 1974.

By /s/ Tom L. Beauchamp, Jr.
President
DRUG MART

Dated at San Antonio, Texas this
12th day of October, 1974.

By /s/ Whitnol H. Gibson
Title: Owner

Internal Revenue Employer Identification No. 74-1496756
or
If you do not have a Tax No.,
your Social Security No. ———————

LETTER FROM STEVE G. McDONALD TO ROBERT C. McANELLY, DATED MARCH 14, 1969 ("EXHIBIT 51" TO DEPOSITION OF ALBERT W. POGUE, DECEMBER 30, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

GROUP LIFE & HEALTH
Insurance Company

[LOGO]

Blue Cross Building — Main at North Central Expressway
Dallas, Texas 75222

March 14, 1969

Mr. Robert C. McAnelly
Supervisor, AHGL Policy Unit
State Board of Insurance
1110 San Jacinto
Austin, Texas 78701

Re: Form No. CC-OHDS-2
Form No. PDPA-1

Dear Mr. McAnelly:

We submit herewith for your approval Form No. CC-OHDS-2 which is a Drug Supplement to our Custom Coverage Group Medical-Surgical Insurance Policy, Form No. MSCC-1, which was approved by your department under Order No. 19427 on 9-27-65. We will use application Form No. MSCC-App. 1, which was approved under the same order number.

I am also enclosing Form PDPA-1 which is the Participating Drug Pharmacy Agreement that Group Life & Health Insurance Company will enter into with pharmacies for the provision of benefits under this supplement.

Letter From Steve G. McDonald to Robert C. McAnelly

I am enclosing a duplicate copy of the supplement and agreement together with this letter in order that you may stamp them and return to us.

If we can furnish additional information concerning these filings, please advise.

Sincerely yours,

GROUP LIFE & HEALTH
INSURANCE COMPANY

/s/ Steve G. McDonald
STEVE G. McDONALD

bjm
Enclosures

[Disapproved By Order No. 29701, Jun. 18, 1969,
Commissioner of Insurance, State of Texas]

[Forms subsequently exempted by Commissioner's Order No. 30413, September 30, 1969, see approved forms files for this file]

**GROUP LIFE AND HEALTH INSURANCE COMPANY
DRUG SUPPLEMENT POLICY, DATED APRIL 1, 1969
("EXHIBIT 52" TO DEPOSITION OF ALBERT W. POGUE,
DECEMBER 30, 1975)**

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

GROUP LIFE & HEALTH

Insurance Company

[LOGO]

Dallas, Texas

has issued this

DRUG SUPPLEMENT

to the

EXPERIENCE RATED GROUP MEDICAL-SURGICAL INSURANCE POLICY

No. 123456 issued heretofore or simultaneously

herewith, to

XYZ COMPANY, INC.

(therewith and herein called the Employer)

as of April 1, 1969

(herein called the supplemental policy date)

and thereby agrees to provide the additional benefits detailed herein,

all in accordance with the conditions and provisions hereof, including those set out on the following pages which are a part of this supplement as fully as if recited over the signatures hereto affixed.

This supplement becomes effective on the supplemental policy date, and is issued in consideration of the application herefor made by the Employer. It will be continued in force subject to the timely payment of premiums herefor, until terminated in accordance with the provisions of the Article captioned "Termination of Drug Coverage."

IN WITNESS WHEREOF, the Insurer has caused this supplement to be executed at its Home Office in Dallas, Texas.

President

Countersigned:

Registrar

**[Disapproved By Order No. 29701, Jun. 18, 1969,
Commissioner of Insurance, State of Texas]**

Drug Supplement Policy (April 1, 1969)

ARTICLE I—SUPPLEMENTAL DEFINITIONS

AS USED HEREIN:

A. GROUP HOSPITALIZATION CONTRACT means an instrument issued by Group Hospital Service, Inc. of Dallas, Texas to the Employer, bearing the same number as that appearing on the "Experience Rated Group Medical-Surgical Insurance Policy" described on the face page hereof, including any supplements thereto.

B. GROUP MEDICAL-SURGICAL INSURANCE POLICY means the "Experience Rated Group Medical-Surgical Insurance Policy" described on the face page hereof.

C. BASIC COVERAGE means the total amount of protection afforded a participant by both the group hospitalization contract and the group medical-surgical insurance policy on account of expense incurred for drugs and medicines.

D. COVERED DRUGS means any Prescription Legend Drug or injectable insulin:

(1) which is ordered by a physician;

(2) for which a written prescription order is customarily prepared;

(3) for which a separate charge is customarily made; and

(4) which is not entirely consumed at the time and place that the prescription order is written.

E. PRESCRIPTION LEGEND DRUG means any medicinal substance—the label of which, under the Federal Food, Drug, and Cosmetic Act, as amended, is

Drug Supplement Policy (April 1, 1969)

requi[illegible] to bear the legend: "Caution: Federal Law prohibits dispensing without prescription."

F. DRUG DEDUCTIBLE means the amount to be paid by a participant toward the cost of the initial purchase of each covered drug and toward the cost of each refill purchase of each covered drug and for each such purchase and is equal to the amount specified in Item 20 of the schedule.

G. PRESCRIPTION ORDER means a request for medication by a physician.

H. PHARMACY means a licensed establishment where Prescription Legend Drugs are dispensed by a person who is not a practitioner of the healing arts and who is licensed to dispense such drugs under the laws of the state in which he practices.

I. PROVIDER means any pharmacy, physician, or any other person or organization legally licensed to dispense drugs.

J. PARTICIPATING PROVIDER means a provider located in the State of Texas with which the Insurer or Group Hospital Service. Inc. of Dallas, Texas, has entered into a written contract for the rendition of covered drugs for which benefits are provided by this supplement, or any provider located outside the State of Texas with which any other Blue Cross or Blue Shield Plan has entered into such a contract.

K. NON-PARTICIPATING PROVIDER means a provider who is not a participating provider.

ARTICLE II—TERMS AND PROVISIONS

A. All definitions, limitations, and provisions recited in the group medical-surgical insurance policy are hereby adopted and shall be construed to apply in like manner

and with equal force to this supplement, any provisions insofar as they are in conflict with provisions herein contained, in which case the provisions of this supplement shall govern in any interpretations of rights or obligations accruing hereunder.

B. It is hereby specially declared that the non-duplication provisions set forth in Article IV, Section F, of the group medical-surgical insurance policy are applicable to this supplement except insofar as they are modified by the provisions of the following subsections:

1. Determination of drug benefits under this supplement shall be made in relation to each "claim," consisting of any combination of charges for covered drugs which are incurred within a calendar year and submitted at one time by or on behalf of a participant to the Insurer at his request for payment of drug benefits applicable thereto.

2. When the non-duplication provisions are applicable, the benefits of the other coverage and all benefits provided under the basic coverage on the items composing the claim shall be deducted from the charges for all such items, and the Insurer will pay the remainder; provided, however, that in no event shall these provisions be construed to increase the amount of total benefits which would be payable under this supplement on account of such claim in the absence of other coverage.

ARTICLE III—BENEFITS

A. Subject to the exclusions, limitations, and all other terms and provisions set forth herein, any participant shall be entitled to receive covered drugs from any participating provider as a benefit hereunder and shall be required to pay no more than the drug deductible for each of such covered drugs.

B. Any participant receiving covered drugs from a non-participating provider shall be entitled to benefits equal to 75% of the usual and customary charges for such covered drugs as determined by the Insurer, reduced by the drug deductible for such covered drugs; except that for covered drugs received from a non-participating provider located outside of the State of Texas, such participant shall be entitled to benefits equal to 100% of the usual and customary charges for such covered drugs, reduced by the drug deductible for each such covered drugs.

C. Payment of benefits by the Insurer to the provider or to the Employer, as the Insurer may elect, shall constitute full discharge of all responsibility of the Insurer to the employee on account of care rendered to any participant under his coverage.

ARTICLE IV—LIMITATIONS AND EXCLUSIONS

In addition to the limitations and exclusions stipulated in Article VI of the group medical-surgical insurance policy, it is provided that no drug benefit shall be available for any of the following:

A. Any charge for a contraceptive medication, even if such medication is a Prescription Legend Drug, and any charge for therapeutic devices or appliances (including but not by way of limitation, hypodermic needles, syringes, support garments, and other non-medicinal substances) regardless of their intended use.

B. Any charge for services other than Covered Drugs, including administration of a Prescription Legend Drug or injectable insulin.

C. The charge for more than a 34-day supply of a medication, except that Blue Cross-Blue Shield will cover 100 unit doses (e.g. tablet or capsule) of a natural thyroid product and 100 unit doses of nitroglycerine.

D. The charge for any prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from the physician's order.

E. Covered Drugs for which no charge is customarily made.

F. Covered Drugs to the extent that a benefit is provided therefor under the basic coverage.

ARTICLE V—TERMINATION OF DRUG COVERAGE

A. This supplement and coverage of all participants hereunder shall automatically terminate:

1. When the group medical-surgical insurance policy is terminated for any reason;
2. Upon default in payment of supplemental premiums, subject to the grace period and reinstatement provided for in the group medical-surgical insurance policy;
3. Upon cancellation of this supplement in any manner as specified in the group medical-surgical insurance policy for cancellation thereof.

B. The coverage of any participant under this supplement shall automatically terminate when his coverage under the group medical-surgical insurance policy is terminated, subject, however, to refund of supplemental premiums paid in advance, as therein provided.

C. Under no circumstances shall the Plan be obligated to notify any participant of the termination of this supplement or of his coverage hereunder.

D. No conversion privilege afforded a participant under the group medical-surgical insurance policy shall be deemed to apply to this supplement.

ARTICLE VI—GENERAL PROVISIONS

A. DISCLOSURE AUTHORIZATION. In consideration of the Insurer's having waived physical examination in connection with the application herefor, the employee on behalf of himself and his covered dependents and sponsored dependents shall be deemed to have authorized any provider to make available to the Insurer information relating to all prescription orders, copies thereof and other records as needed by the Insurer.

B. The Insurer shall not be liable for any claim or demand for injuries or damage arising out of or in connection with the manufacturing, compounding, dispensing or use of any Prescription Legend Drugs or insulin, whether or not covered under this supplement.

C. The Insurer reserves the right to deny benefits for any drug prescribed or dispensed in a manner contrary to normal medical or pharmaceutical practice.

Drug Supplement Policy (April 1, 1969)

PARTICIPATING DRUG PHARMACY AGREEMENT

between

GROUP LIFE & HEALTH INSURANCE COMPANY

(Herein called Blue Shield)

Dallas, Texas

and

_____

(Herein called the Participating Pharmacy)

_____

(Type of Organization)

_____

(Address)

Pharmacy Permit No. _____

1. The Participating Pharmacy agrees that all pharmacists dispensing drugs in its behalf are to be considered participating pharmacists. The pharmacists currently employed by the Participating Pharmacy are:

Name	License No.
_____	_____
_____	_____
_____	_____

Drug Supplement Policy (April 1, 1969)

2. The Participating Pharmacy shall dispense drugs for which benefits are provided under Blue Shield's Drug Supplement CC-OHDS-2 or any other supplement or contract upon written notice by Blue Shield, to persons who are entitled to benefits under such supplements, all in accordance with the terms of such instruments.

3. The Participating Pharmacy agrees to accept as full payment for each drug provided under Section 2, above, of this agreement an amount equal to the total of the acquisition cost for such drug and a professional dispensing fee of $_____. Acquisition cost, as used in this agreement, means the actual cost of a drug to the Participating Pharmacy, as determined under rules and regulations published by Blue Shield.

4. Blue Shield agrees to pay to the Participating Pharmacy for each drug dispensed under Section 2 of this agreement an amount equal to the excess, if any, of the amount stipulated in Section 3, above, of this agreement over the drug deductible amount, if any, stipulated in the instrument under which drug benefits are available, and the Participating Pharmacy agrees that its charge for such drug to any other person shall not exceed such drug deductible.

5. Blue Shield agrees to provide the Participating Pharmacy with a manual which will stipulate the drugs for which benefits are available and drug deductible applicable to each person to whom drugs are to be dispensed under Section 2 of this agreement, and in which identification codes for certain of the drugs for which benefits are provided will be stipulated. The Participating Pharmacy agrees to include on those claims for benefits the code for the drug for which claim is made if such code is shown in the Participating Pharmacy's current manual.

Drug Supplement Policy (April 1, 1969)

6. All contracts or transactions in which the Participating Pharmacy engages involving dispensing of drugs shall be between the Participating Pharmacy and the patient and Blue Shield shall not be a party thereto.

7. The Participating Pharmacy agrees that Blue Shield shall have the right to inspect all records pertaining to persons eligible for benefits under its drug supplements at any time during regular business hours.

8. The Participating Pharmacy agrees not to engage in any advertising relative to Blue Shield drug supplements without prior approval of Blue Shield.

9. This agreement may be terminated at any time by either party by giving at least 15 days prior written notice to the other party.

GROUP LIFE & HEALTH
INSURANCE COMPANY

Dated at Dallas, Texas
this — day of ———,
19 ——.

By _____
President

_____

Dated at ———, Texas
this — day of ———,
19 ——.

By _____
Title:

OFFICIAL ORDER NO. 29701 OF TEXAS COMMISSIONER OF INSURANCE, DATED JUNE 18, 1969 ("EXHIBIT 53" TO DEPOSITION OF ALBERT W. POGUE, DECEMBER 30, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

No. 29701

OFFICIAL ORDER

of the

COMMISSIONER OF INSURANCE

of the

STATE OF TEXAS
AUSTIN, TEXAS

Date June 18, 1969

Subject Considered:

APPROVAL OF FORMS

General remarks and official action taken:

On this date came on for consideration by the Commissioner of Insurance application for approval of Form No. CC-OHDS-2 filed by Group Life & Health Insurance Company and the Commissioner, having found that said form does not comply with the requirements of Article 3.42, Texas Insurance Code, as amended, hereby disapproves said form under authority of the cited statute, and herenow states his grounds for such disapproval as follows:

Under provision of said form the differentiation of benefits as between "participating provider" dispensed drugs and "non-participating provider" dispensed drugs constitutes unfair discrimination within the meaning of Article 21.21, Texas Insurance Code.

Official Order No. 29701, June 18, 1969

The provisions of said form are violative of the anti-trust and monopoly statutes of this state.

Prepared, recommended and approved by:

/s/ R. C. McAnelly
R. C. McANELLY,
Supervisor
Health and Group Life
Policy Unit
Life Division

COMMISSIONER OF INSURANCE

By /s/ Don B. Odum
DON B. ODUM,
Section Manager
Life Division

[Revised by Order 30413 A & H 9/30/69]

LETTER FROM PAUL D. CONNOR TO HON. CRAWFORD MARTIN, DATED AUGUST 21, 1969 ("EXHIBIT 54" TO DEPOSITION OF ALBERT W. POGUE, DECEMBER 30, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

Ned Price
Member

George M. Cowden
Chairman

Durwood Manford
Member

Clay Cotten
Commissioner of Insurance

[SEAL]

STATE BOARD OF INSURANCE
1110 San Jacinto
AUSTIN, TEXAS 78701

August 21, 1969

Honorable Crawford Martin
Attorney General of Texas
Capitol Station
Austin, Texas 78711

Re: Medi-MET Prescription Drug Plan—
General Motors Corporation

Dear Sir:

A domestic stock life insurance company by the name of Group Life and Health Insurance Company, Dallas, Texas, recently submitted its policy Form CC-OHDS-2 for our approval. A copy of this form is enclosed. It was disapproved by Commissioner's Order No. 29701, dated June 18, 1969, and a copy of that Order is also enclosed. You will note that the primary basis for disapproval was that the form's use would result in a violation of the anti-trust and monopoly statutes of Texas.

Group Life and Health Insurance Company did not appeal from the Commissioner's disapproval, and therefore this particular case is moot. However, this insured did call our attention to the fact that Metropolitan Life

Letter from Paul D. Connor to Hon. Crawford Martin

Insurance Company, a New York insurer licensed in Texas, does have an equivalent plan in effect in this state. Since Metropolitan is a foreign corporation and since the master contract was issued outside of Texas, there was no requirement that the policy be filed with the Commissioner of Insurance of Texas. For this reason, we were unable to raise the anti-trust and monopoly questions by disapproval of a policy form as we have done in the Group Life and Health case.

In any event, we did notify Metropolitan Life Insurance Company that a plan equivalent to theirs had been disapproved when submitted by Group Life and Health Insurance Company. At the request of Metropolitan Life Insurance Company and its attorneys, Vinson, Elkins, Searls & Connally, a conference was held in our offices on August 13, 1969. Assistant Attorney General Joe A. Longley was present at this conference as a result of our telephone invitation to your Anti-Trust Division.

The officers and attorneys from Metropolitan Life were completely cooperative in disclosing their plan of operation to us. They also presented certain documents for the purpose of fully outlining the factual operations under their contract with General Motors Corporation. The documents which they submitted are enclosed herewith.

As we have previously stated, no appeal was taken by Group Life and Health Insurance Company, and therefore no question of anti-trust violation is pending before the State Board of Insurance. Since Metropolitan Life is not required to file the form of policy which it issues in a foreign state (even though some of the covered employees are residents of Texas), Metropolitan's contracts with General Motors and with the various druggists of Texas are not before the State Board of Insurance for consideration. If the activities of Metropolitan Life are

Letter from Paul D. Connor to Hon. Crawford Martin

in violation of the Texas anti-trust act, they would nevertheless appear to be beyond the jurisdiction of the State Board of Insurance. For that reason, this letter and the attached documents are being submitted to you for information only.

Very truly yours,

Commissioner of Insurance

By

Paul D. Connor
Assistant to the Commissioner

PDC:lce
Encls.

OFFICIAL ORDER NO. 30413 OF TEXAS COMMISSIONER OF INSURANCE, DATED SEPTEMBER 30, 1969 ("EXHIBIT 55" TO DEPOSITION OF ALBERT W. POGUE, DECEMBER 30, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

No. 30413

OFFICIAL ORDER

of the

COMMISSIONER OF INSURANCE

of the

STATE OF TEXAS
AUSTIN, TEXAS

Date Sep. 30, 1969

Subject Considered: POLICY FORM APPROVAL—

EXEMPTION FROM THE REQUIREMENTS OF ARTICLE 3.42, TEXAS INSURANCE CODE

General remarks and official action taken:

Pursuant to the authority granted by Article 3.42, Paragraph (e) of the Texas Insurance Code, the Commissioner of Insurance hereby exempts from the requirements of said Article Policy Form CC-OHDS-2 submitted by Group Life and Health Insurance Company, Dallas, Texas; and this exemption shall remain effective pending further orders from the Commissioner of Insurance. To the extent that this exemption order conflicts with Commissioner's Order No. 29701, dated June 18, 1969, Order No. 29701 is superseded.

This exemption order shall also apply to any form, identical in content to Form CC-OHDS-2, delivered, issued or used in this state by any licensed insurer.

This exemption order is issued and published for the reason that, in the opinion of the Commissioner, Article 3.42 of the Texas Insurance Code may not practicably be applied at this time to the forms covered by the exemption. The exempt forms are described as drug service contracts, which confer upon the policyholder the right to obtain certain prescribed drugs at a cost fixed in the contract, the insurer having entered into participating agreements with dispensing pharmacies to supply the prescribed drugs to its policyholders.

The policy forms herein exempt, used in connection with the participating agreements with pharmacies as described above, have raised questions under the Texas anti-trust and anti-monopoly laws, and such questions have been referred to the Attorney General of the State of Texas. Pending such time as these questions are resolved, the exemptions authorized by this Order are granted for the purpose of preventing any competitive advantages which foreign insurance companies, issuing policies outside of Texas but including Texas residents under their coverage, might have over domestic companies seeking to issue equivalent policy contracts.

/s/ Clay Cotten
CLAY COTTEN
Commissioner of Insurance

Prepared by:

/s/ Paul D. Connor
PAUL D. CONNOR
Assistant to the Commissioner

LETTER FROM PAUL D. CONNOR TO HON. CRAWFORD MARTIN, DATED OCTOBER 1, 1969 ("EXHIBIT 56" TO DEPOSITION OF ALBERT W. POGUE, DECEMBER 30, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

October 1, 1969

Honorable Crawford Martin
Attorney General of Texas
Capitol Station
Austin, Texas 78711

Attention: Mr. Robert Owen

Re: Medi-MET Prescription Drug Plan—
General Motors Corporation

Dear Sir:

This will supplement our letter of August 21 on the above subject, and our telephone conversation of several days ago. After discussing this case with the Commissioner, it was determined that an exemption order should be issued to prevent an unfair competitive advantage which foreign insurance companies might have in the absence of the exemption order. It is, of course, intended that the order will remain in effect only long enough to permit us to resolve any questions of anti-trust law violations.

It is our understanding from Mr. Philip Overton, a local attorney at law who represents Group Life and Health Insurance Company, that the auto manufacturers had put a very short deadline on bids for this coverage. We understand that this deadline was dictated by agreements made between the auto manufacturers and the United Auto Workers of America. It was decided that

the exemption order would relieve the urgency of resolving the anti-trust questions, giving us time to brief the law with deliberation.

We are making no opinion request at this time, since we do not believe that an Attorney General's Opinion would serve any immediate administrative purpose for the State Board of Insurance. In due time, of course, we would like to be advised of any decision or action taken by the Attorney General in the premises, so that we can withdraw our exemption order or take such other action as we deem appropriate.

Very truly yours,

Commissioner of Insurance

By

Paul D. Connor
Assistant to the Commissioner

PDC:lce
Encl.—Copy of Commissioner's Order No. 30413

CC: Mr. Don B. Odum
Mr. Robert C. McAnelly

LETTER FROM STEVE G. McDONALD TO A. W. POGUE, DATED SEPTEMBER 23, 1974 ("EXHIBIT 57" TO DEPOSITION OF ALBERT W. POGUE, DECEMBER 30, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

Tom L. Beauchamp, Jr., President

GROUP LIFE & HEALTH
Insurance Company

[LOGO]

Main at North Central Expressway
P. O. Box 5403—Dallas, Texas 75222

September 23, 1974

Mr. A. W. Pogue, Manager
Headquarters Section, Life Division
State Board of Insurance
1110 San Jacinto
Austin, Texas 78786

Re: MF-1, Experience Rated Group Hospitalization and Medical-Surgical Contract
MF-1-DS-1, Drug Supplement
MF-1-APP-1, Group Application Blank
MF-1-OA-1, Operating Agreement
MF-1-IA-1, Insurance Agreement

Dear Mr. Pogue:

We submit herewith for your approval the above described new contract forms.

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

Letter from Steve G. McDonald to A. W. Pogue

We anticipate entering into a health care program agreement with the Bexar County Medical Foundation wherein Blue Shield of Texas will provide benefits as set forth in Form Nos. MF-1, Article VII, and MF-1-DS-1 to groups desiring this coverage. The Bexar County Medical Foundation will provide medical-surgical benefits as set forth in a separate contract, a copy of which will be sent to you in a few days for information purposes only.

We are also submitting for your approval the operating and reinsurance agreements between Blue Cross and Blue Shield of Texas and the Bexar County Medical Foundation. The attached list indicates our internal stock control numbers used for these various forms.

Within the next few weeks we will submit the certificate-booklet and enrollment application card for your approval.

We are submitting two copies of each form described above, together with an extra copy of this letter. Will you please stamp the extra copy of each "approved" and return to us for our files. These same forms are being concurrently filed by Group Hospital Service, Inc.

If additional information is needed regarding this filing, please call me in order that we may discuss the matter more in detail by telephone.

Yours very truly,

Group Life & Health
Insurance Co.

/s/ Steve G. McDonald
STEVE G. McDONALD

SGMcD:jc

Encs.
cc: Mr. Joe Hawkins, Mr. John Holden

Letter from Steve G. McDonald to A. W. Pogue

MF-1, Experience Rated Group Hospitalization and Medical-Surgical Contract (between Blue Cross and Blue Shield and the Group)

1600-974	Face Page	
1601-974	Article I	
1602-974	Article I	(Page 2)
1603-974	Article I	(Page 3)
1604-974	Article I	(Page 4)
1605-974	Article II	
1606-974	Article II	(Page 2)
1607-974	Article II	(Page 3)
1608-974	Article III	
1609-974	Article IV	
1610-974	Article IV	(Page 2)
1611-974	Article V	
1612-974	Article V	(Page 2)
1613-974	Article V	(Page 3)
1618-974	Article VII	
1619-974	Article VII	(Page 2)
1620-974	Article VII	(Page 3)
1621-974	Article VIII	
1622-974	Article VIII	(Page 2)
1623-974	Article IX	
1624-974	Article IX	(Page 2)
1625-974	Article X	
1626-974	Article XI	
1627-974	Article XI	(Page 2)
1628-974	Article XI	(Page 3)

MF-1-DS-1, Drug Supplement

1629-974	Face Page
1630-974	Article I
1631-974	Article II
1632-974	Article III
1633-974	Article IV
1634-974	Article V
1635-974	Article VI

MF-1-APP-1, Group Application Blank

1636-974	Page 1
1637-974	Page 2

GROUP LIFE AND HEALTH INSURANCE COMPANY DRUG SUPPLEMENT POLICY, DATED OCTOBER 1, 1974 ("EXHIBIT 59" TO DEPOSITION OF ALBERT W. POGUE, DECEMBER 30, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

[LOGO]

GROUP LIFE & HEALTH INSURANCE CO.
(Herein called Blue Shield of Texas)

Dallas, Texas

has issued this

DRUG SUPPLEMENT

to the

EXPERIENCE RATED GROUP HOSPITALIZATION AND MEDICAL-SURGICAL CONTRACT

No. 34567

issued heretofore or simultaneously herewith, to

ABC COMPANY
(therewith and herein called the Employer)

as of October 1, 1974
(herein called the supplemental contract date)

and thereby agrees to provide
the additional benefits detailed herein,

[Approved By Order No. 45511, Oct. 1, 1974,
Commissioner of Insurance, State of Texas]

all in accordance with the conditions and provisions hereof, including those set out on the following pages which are a part of this supplement as fully as if recited over the signatures hereto affixed.

This supplement becomes effective on the supplemental contract date, and is issued in consideration of the application herefor made by the Employer. It will be continued in force subject to the timely payment of premiums herefor, until terminated in accordance with the provisions of the Article captioned "Termination of Drug Coverage."

IN WITNESS WHEREOF, Blue Shield of Texas has caused this supplement to be executed at its Home Office in Dallas, Texas.

/s/ Thomas Beauchamp, Jr.
President

/s/ Boone Powell
Secretary

Countersigned:

Registrar

ARTICLE I—SUPPLEMENTAL DEFINITIONS

AS USED HEREIN:

A. BASIC CONTRACT means the "Experience Rated Group Hospitalization and Medical-Surgical Contract" described on the face page hereof.

B. BASIC COVERAGE means the total amount of protection afforded a participant by the basic contract on account of expense incurred for drugs and medicines.

C. COVERED DRUGS means any Prescription Legend Drug or injectable insulin:

(1) which is ordered by a physician;

(2) for which a written prescription order is customarily prepared;

(3) for which a separate charge is customarily made;

(4) which is not entirely consumed at the time and place that the prescription order is written; and

(5) which is received by the participant while covered hereunder.

D. PRESCRIPTION LEGEND DRUG means any medicinal substance—the label of which, under the Federal Food, Drug, and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription."

E. DRUG DEDUCTIBLE means the amount to be paid by a participant toward the cost of the initial purchase of each covered drug and toward the cost of each refill purchase of each covered drug and for each such purchase and is equal to two dollars ($2.00).

F. PRESCRIPTION ORDER means a request for medication by a physician.

G. PHARMACY means a licensed establishment where Prescription Legend Drugs are dispensed by a person who is not a practitioner of the healing arts and who is licensed to dispense such drugs under the laws of the state in which he practices.

H. PROVIDER means any pharmacy, physician, or any other person or organization legally licensed to dispense drugs.

I. PARTICIPATING PROVIDER means a provider located in the State of Texas with which Blue Shield of Texas or Group Hospital Service, Inc. of Dallas, Texas, has entered into a written contract for the rendition of covered drugs for which benefits are provided by this supplement, or any provider located outside the State of Texas with which any other Blue Cross or Blue Shield Plan has entered into such a contract.

J. NON-PARTICIPATING PROVIDER means a provider who is not a participating provider.

ARTICLE II—TERMS AND PROVISIONS

A. All definitions, limitations, and provisions recited in the basic contract are hereby adopted and shall be construed to apply in like manner and with equal force to this supplement and any other provisions insofar as they are in conflict with provisions herein contained, in which case the provisions of this supplement shall govern in any interpretation of rights or obligations accruing hereunder.

B. It is hereby specially declared that the non-duplication provisions set forth in Article V, Section E, of the basic contract are applicable to this supplement except insofar as they are modified by the provisions of the following subsections:

1. Determination of drug benefits under this supplement shall be made in relation to each "claim," consisting of any combination of charges for covered drugs which are incurred within a calendar year and submitted at one time by or on behalf of a participant to Blue Shield of Texas at his request for payment of drug benefits applicable hereto.

2. When the non-duplication provisions are applicable, the benefits of the other coverage and all benefits provided under the basic coverage on the items composing the claim shall be deducted from the charges for all such items, and Blue Shield of Texas will pay the remainder; provided, however, that in no event shall these provisions be construed to increase the amount of total benefits which would be payable under this supplement on account of such claim in the absence of other coverage.

ARTICLE III—BENEFITS

A. Subject to the exclusions, limitations, and all other terms and provisions set forth herein, any participant shall be entitled to receive covered drugs from any participating provider as a benefit hereunder and shall be required to pay no more than the drug deductible for each of such covered drugs.

B. Any participant receiving covered drugs from a non-participating provider shall be entitled to benefits equal to 75% of the result of the reasonable charge for such covered drugs as determined by Blue Shield of Texas, reduced by the drug deductible for such covered drugs; except that for covered drugs received from a non-participating provider located outside of

the State of Texas, such participant shall be entitled to benefits equal to 100% of the reasonable charge for such covered drugs, reduced by the drug deductible for each such covered drugs.

C. Payment of benefits by Blue Shield of Texas to the provider or to the employee, as Blue Shield of Texas may elect, shall constitute full discharge of all responsibility of Blue Shield of Texas to the employee on account of care rendered to any participant under his coverage.

ARTICLE IV—LIMITATIONS AND EXCLUSIONS

In addition to the limitations and exclusions stipulated in Article VIII of the basic contract, it is provided that no drug benefit shall be available for any of the following:

A. Any charge for a contraceptive medication, even if such medication is a Prescription Legend Drug, and any charge for therapeutic devices or appliances (including but not by way of limitation, hypodermic needles, syringes, support garments, and other non-medicinal substances) regardless of their intended use;

B. Any charge for services other than Covered Drugs, including administration of a Prescription Legend Drug or injectable insulin;

C. The charge for more than a 34-day supply of a medication, except that Blue Shield of Texas will cover 100 unit doses (e.g. tablet or capsule) of a natural thyroid product and 100 unit doses of nitroglycerine;

D. The charge for any prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from the physician's order;

E. Covered Drugs for which no charge is customarily made;

F. Covered Drugs to the extent that a benefit is provided therefor under the basic coverage;

G. Covered Drugs which are not medically necessary.

ARTICLE V—TERMINATION OF DRUG COVERAGE

A. This supplement and coverage of all participants hereunder shall automatically terminate:

1. When the basic contract is terminated for any reason;

2. Upon default in payment of supplemental premiums, subject to the grace period and reinstatement provided for in the basic contract;

3. Upon cancellation of this supplement in any manner as specified in the basic contract for cancellation thereof.

B. The coverage of any participant under this supplement shall automatically terminate when his coverage under the basic contract is terminated, subject, however, to refund of supplemental premiums paid in advance, as therein provided.

C. Under no circumstances shall Blue Shield of Texas be obligated to notify any participant of the termination of this supplement or of his coverage hereunder.

D. No conversion privilege afforded a participant under the basic contract shall be deemed to apply to this supplement.

ARTICLE VI—GENERAL PROVISIONS

A. DISCLOSURE AUTHORIZATION. In consideration of Blue Shield of Texas having waived a physical

Drug Supplement Policy (October 1, 1974)

examination in connection with the application herefor, the employee on behalf of himself and his covered dependents shall be deemed to have authorized any provider to make available to Blue Shield of Texas information relating to all prescription orders, copies thereof and other records as needed by Blue Shield of Texas.

B. Blue Shield of Texas shall not be liable for any claim or demand for injuries or damage arising out of or in connection with the manufacturing, compounding, dispensing or use of any Prescription Legend Drug or insulin, whether or not covered under this supplement.

C. Blue Shield of Texas reserves the right to deny benefits for any drug prescribed or dispensed in a manner contrary to normal medical or pharmaceutical practice.

OFFICIAL ORDER NO. 45511 OF TEXAS COMMISSIONER OF INSURANCE, DATED OCTOBER 1, 1974 ("EXHIBIT 61" TO DEPOSITION OF ALBERT W. POGUE, DECEMBER 30, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

No. 45511

OFFICIAL ORDER

of the

COMMISSIONER OF INSURANCE

of the

STATE OF TEXAS
AUSTIN, TEXAS

Date Oct. 1, 1974

Subject Considered:

General remarks and official action taken:

On this date came on for consideration by the Commissioner of Insurance applications for approval of the forms described herein; and the Commissioner, having found that each of said forms complies with the requirements of Article 3.42, Texas Insurance Code, as amended, hereby approves each of said forms under authority of the cited statute:

Official Order No. 45511, October 1, 1974

Submitted By:	*Identifying Form Nos.:*
Group Hospital Service, Inc. Group Life & Health Insurance Company	MF-1 with; MF-1-APP-1 attached; MF-1-DS-1.

This approval is extended for use as the insurer portion of a Group Comprehensive Medical Care Plan and such approval is limited and does not constitute approval of the said form for any other use under the Texas Insurance Code.

/s/ Don B. Odum
DON B. ODUM
Commissioner of Insurance

Prepared, recommended and approved by:

/s/ Mildred R. Kurt
(Mrs.) MILDRED R. KURT, Supervisor
Health and Group Life Policy Unit
Life Division

EXCERPTS FROM DEPOSITION OF PAUL D. CONNOR, DECEMBER 30, 1975

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

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* * * *

[3] DIRECT EXAMINATION

Questions by Mr. Kaiser:

Q Would you state your full name, please?
A My name is Paul D. Connor.
Q Mr. Connor, what is your address?
A I live at 2612 Wooldridge Drive, Austin, Texas.
Q What is your business address, Mr. Connor.
A 505 West 12th Street, Austin.
Q Mr. Connor, were you served with a subpoena requesting your appearance here today?
A Yes, sir, I was.
Q Mr. Connor, what is your occupation?
A I am a lawyer.
Q When were you licensed to practice, sir?
A 1949.
[4] Q What firm do you practice with, Mr. Connor?
A Flahive and Ogden.
Q Mr. Connor, just for your benefit, let me introduce the counsel that are here at the table. My name is Keith Kaiser, and I represent Group Life and Health Insurance Company, and throughout this deposition this afternoon I will refer to it as Blue Shield of Texas or just simply Blue Shield. To my immediate left is Larry Macon of our firm who is my co-counsel in this case. To your right, immediate right is Mr. Bill Church who represents Walgreens Drug Stores. To Mr. Church's right is Charles Shaddox who represents Reiger-Medi-Save, and at the far end of the table is Mr. Joel Pullen who represents the Plaintiffs in this lawsuit. There is one other De-

Excerpts from Deposition of Paul D. Connor

fendant involved in the suit and that is Sommers Drug Stores, and counsel for Sommers is not here today.

A Thank you, sir.

Q This particular suit pertains to an anti trust action that has been filed by Mr. Pullen on behalf of his clients. His clients are 17 or 18 independent pharmacists in San Antonio, and this is an anti trust action which arises out of the operation or certain operations of Blue Shield, and in particular, the issuance of a pre-paid prescription drug supplement and third party contracts or drug service contracts with participating pharmacists. [5] Mr. Connor, I think it would be kind of ludicrous for me to give you the standard preliminary instructions that I give a witness when I take a deposition, so we will just pass by those because I am sure you have been involved in hundreds of depositions during your legal career. Can you tell me where you graduated from law school, sir?

A Yes. At the University of Texas.

Q What did you do—it is my understanding that you graduated in 1949.

A '49.

Q Where did you go to work then, sir?

A I was immediately employed by the State Board of Insurance which was called the Board of Insurance Commissioners at that time, and I continued in the employ of that agency until three years ago, about.

Q In what capacity were you employed when you first went to work for the State Board?

A Initially I was counsel, legal counsel for the Board of Insurance, and that covered a period of about ten years. The remaining part of my tenure was Deputy Commissioner or Assistant Commissioner of Insurance.

Q Would you tell me when you became Deputy Commissioner or Assistant Commissioner of Insurance, the year as best you can recall?

Excerpts from Deposition of Paul D. Connor

[6] A Possibly 1957. That would be a little difficult; 8 years, ten years, or something like that.

Q Can you tell me which title, Deputy Commissioner or Assistant Commissioner, because we may be referring to that?

A I actually—I don't know. There were several different titles given over a period of time, so Deputy Commissioner is about as accurate as any.

Q All right. As Deputy Commissioner of the State Board of Insurance can you tell me what your duties encompassed?

A I was the first Assistant to the Commissioner and therefore replaced the Commissioner in his absence. I was the first Administrative Assistant to the Commissioner, therefore my duties were somewhat the same as the Commissioner's duties.

Q In the absence of the Commissioner did you have decision making authority?

A Yes, I did.

Q In the absence of the Commissioner did you have all of the decision making authority that the Commissioner would have if he were present?

A In practice I did exercise the authority which he would have had he been present. His absences were generally a very short duration, therefore I did not see fit to take over unless there was some urgency, and I would [7] await his return.

Q Mr. Connor, am I correct in saying that you were Deputy Commissioner from 19—pardon me, from 1957 until such time as you left the Board in what year?

A In 1972.

Q Mr. Connor, I think maybe we can expedite matters just a little bit if I showed you some documents that have previously been marked in deposition proceedings here today and which have been identified as being from the official records of the State Board of Insurance, in par-

ticular, the policy approval division. I hand you what has been marked as Deposition Exhibit 52. I will just keep on going, so I will hand you Deposition Exhibits 53, 54, 55 and 56, inclusive.

A I have reviewed those Exhibits briefly.

Q Mr. Connor, it is my understanding from previous testimony that in the latter part of 1969, say somewhere around—pardon me—mid 1969, a particular drug supplement was submitted by Blue Shield to the State Board of Insurance for approval. I will hand you what has been marked as Deposition Exhibit 52 and mention to you that Mr. McAnelly has previously testified and said that the policy was submitted to him and he reviewed it prior to the Board taking any official action on it. Now, Mr. McAnelly has testified that at the time he [8] reviewed the policy he had various conversations with you, or he brought the policy to your attention. Do you recall this particular policy, sir?

A I have no real recollection of this policy. I have a vague recollection of having discussed this type of policy with Mr. McAnelly at that time.

Q Would it have been in the regular course of business for the—for someone in the Approval Division to come to you to discuss problems over policy approval?

A Yes, sir.

Q Mr. Connor, I hand you what has been marked as Deposition Exhibit 53 which is an official order of the Insurance Commissioner disapproving the policy that I have just previously handed you which should have been Exhibit 52. Do you recall discussing that disapproval order with Mr. McAnelly before it was issued?

A This has been six years ago, and by having recently reviewed this whole file, I have a very vague memory of the disapproval and the events which followed it, more particularly, an isolated thing. I do not recall discussing the entry of the disapproval order.

Q Do you recall discussing with Mr. McAnelly the objections set out in the disapproval order which refer to Article 21.21 of the Insurance Code?

A I do not. I remember that the—I do not remember the [9] basis of the order independently of reading the order now in front of me.

Q All right, sir. Mr. Connor, I am going to hand you what has previously been marked as Deposition Exhibit 54, and I would ask you, sir, if you can identify that document.

A Yes, sir, I can.

Q Would you identify it for the record, please?

A This is a letter dated August 21, 1969, addressed to Honorable Crawford Martin, Attorney General of Texas, and written by me.

Q All right, sir. Does this letter which I handed you which is Deposition Exhibit 54, refresh your recollection with respect to any of the problems that were encountered with the policy which was later disapproved?

A Well, there is no refreshing of recollection on my memory of the entry of the order or the form itself, but I do recall having written the letter and the reason for having written the letter. To that extent my memory is refreshed, yes.

Q Mr. Connor, going back to the disapproval order which has been marked Deposition Exhibit 53, do you have any recollection of providing any input to Mr. McAnelly relating to the possible violation by the policy of the antitrust and antimonopoly statutes of the State of Texas?

A I don't recall it.

[10] Q Mr. Connor, I am going to hand you what has been marked as Deposition Exhibit 55 which has been previously identified as an official order of the Commissioner of Insurance dated September 30, 1969. I will ask you to read that, sir.

Excerpts from Deposition of Paul D. Connor

A All right, sir. Do you want me to read it in its entirety?

Q No. Just read it to yourself, please.

A Oh, I see.

Q Just to refresh yourself.

A I have completed the reading of it.

Q All right, sir. Mr. Connor, do you recall any background to the issuance of that exemption—

MR. KAISER: Strike that question, please.

Q Let me ask you, sir, do you recognize your signature in the lower right-hand corner—lower left-hand corner?

A Yes, sir, it is my signature.

Q Do you recognize the signature of Mr. Clay Cotten who was at that time Commissioner of Insurance?

A Yes, sir, I do. It is his signature.

Q Now, it is my understanding, sir, from this document that you prepared it. Do you recall any of the background information as to why the exemption order was granted?

A Yes, sir. I think part of the background information is contained in the letter of August 21 which is Exhibit [11] 54, Deposition Exhibit 54. I do recall part of the background which went into the publication of this order.

Q What was the background, sir?

A There had been a drug service contract which is your Exhibit 52 had been submitted and disapproved by Exhibit 53, then there was brought to our attention somehow the fact that the contract had been negotiated by some labor union with some—I believe it was United Auto Workers, and it was a part of the fringe benefits which they had negotiated for and that a contract of this kind, the same kind which had been disapproved, for a domestic company was in fact being written by Metropolitan Life Insurance Company, so we had some conferences as Exhibit 54 indicates, and concluded that the proper course would be to exempt the order—I mean exempt the policy form from the requirements of approval, leaving the domestic company which sought to write this coverage, to fulfill the labor union's negotiated agreement with its automobile workers.

Excerpts from Deposition of Paul D. Connor

Q All right, sir. Mr. Connor, is the authority to exempt or not exempt granted by statute, sir?

A Yes, sir. It is found in Article 3.42 of the Insurance Code.

Q Is that a discretionary provision? At least, does that [12] confer discretion upon the Insurance Commissioner in granting an exemption?

A Yes, I think so. The statute I haven't looked at in preparation for this, but it uses some words, as I recall, which indicate that he may exempt when in his discretion he feels it is proper or that the public interests are served or something like that. I would have to open the book to see.

Q All right, sir. To the best of your recollection, in matters pertaining to exemptions, did the Commissioner of Insurance have brought [*sic;* broad] regulatory powers, broad discretionary powers?

A Yes, I think he did.

Q Mr. Connor, I will ask you if you would, sir, to go back and reread the third paragraph in the Exemption Order, please, sir.

A I have read it.

Q All right, sir. Now, I would like to bring another document to your attention which is a portion of Deposition Exhibit 52, the last two pages, if you will, please sir. Prior to drafting the Exemption Order, Mr. Connor, did you—do you recall that you had occasion to review the document which consists of two pages and is attached to Deposition Exhibit 52 and is captioned Participating Drug Pharmacy Agreement?

Excerpts from Deposition of Paul D. Connor

[13] A I do not.

Q You do not recall?

A No.

Q From your reading of the third paragraph in the Exemption Order would it appear to you that you at that time reviewed the document?

A I probably reviewed it or—I probably reviewed the document itself and very likely conferred with Mr. McAnelly or probably Mr. McAnelly in addition to reviewing it, but I have no recollection of reading the document.

Q All right, sir. Mr. Connor, at the time of the issuance of this Exemption Order that you are looking at right now, was it you opinion that this particular contract which is marked Deposition Exhibit 52, along with the Participating Drug Pharmacy Agreement which Blue Shield proposed to issue, was it your opinion that that constituted the business of insurance?

A Yes.

Q Which is subject to regulation by the State Board of Insurance?

A Yes.

Q Now, Mr. Connor, the exemption, as I see it—and, of course, the document speaks for itself, but the exemption was granted pursuant to certain authority contained in Article 3.42 of the Insurance Code. Can you tell me if [14] exempt policies, after the exemption is granted are treated any differently than approved policies?

A I don't believe that there would be any difference. The policy form, of course, is just a contract, and a company with an exemption or with an approval in any case would be authorized to issue that contract.

Q All right, sir. Are policies which have been exempted by the State Board of Insurance subject to the same regulation, control and supervision by the State Board of Insurance as are approved policies?

Excerpts from Deposition of Paul D. Connor

A Yes, I would say exactly the same, or perhaps the degree of regulation may be a little greater with the exempt policy in that the exemption—I believe I am correct in this—can be withdrawn with lesser requirements than would be incumbent upon the department if it sought to disapprove a contract once approved.

Q Mr. Connor, in the fourth paragraph of the Exemption Order it states that the policy forms herein exempt used in connection with the participating agreements with pharmacies as described above have raised questions under the Texas Antitrust and Antimonopoly laws. It continues on there, but that is the pertinent portion I would like to talk about. Were those questions that had been raised—if you recall, sir, were the questions that have been raised strong questions of—under the Antitrust and [15] Antimonopoly Laws, or were they weak in your mind, or do you recall?

A I don't have any recollection whether strong or weak except that the disapproval of the form which is shown by Exhibit 53 would indicate that at that time they were thought to be strong enough to disapprove the form. The exemption order entered later would indicate that they were not thought to be so strong as to prohibit as a kind of a—almost as an injunction matter prohibit the issuance of the contract in the first place, but be weak enough objections to permit the company to go ahead as Metropolitan apparently was already going ahead and to suffer the consequences of violation if there be any. It was almost as if we had a Motion in Limine to stop the doing of what they were proposing to do. We could have stopped it through the medium of refusing to approve and refusing to exempt the contract on which activity was being pursued, but as these Exhibits indicate, the departmental action was to refer the matter to the Attorney General and not to block the doing of what was being done through the device of refusing to allow a form to be used. I am sorry for the length of the answer but

Excerpts from Deposition of Paul D. Connor

that is as clear as I can express the weakness and strength of it.

Q Mr. Connor, I am going to hand you what has been previously [16] marked as Deposition Exhibit 56 and ask you to review that, sir.

A I have reviewed it.

Q All right, sir. Would you identify it for the record, please?

A Yes, sir. This is a letter which I wrote on October 1, 1969, to Honorable Crawford Martin, Attorney General. It supplements my letter of August 21 which is Exhibit 54.

Q Now, was it in the regular course of the business of the State Board of Insurance to refer certain matters which you felt appropriate to the Attorney General for his information?

A Yes, sir.

Q And was that within the power of the State Insurance Board?

A Yes, sir.

Q Did the Attorney General take any action as a result of your letter of October 1, 1969?

A I don't know.

Q Are you saying you are not aware of any action?

A I am not aware of any action.

Q All right, sir. Now, Mr. Connor, would you—

MR. KAISER: Strike that.

Q Mr. Connor, would the granting of an exemption such as the [17] one that you are personally holding, as in Exhibit 55, be a regulatory function of the Commissioner of the State Board of Insurance or the State Board of Insurance?

A It would be the Commissioner of Insurance.

Q Now, while the policy is under an exemption, is it still subject to the prohibitions and sanctions that are set out in the Insurance Code of the State of Texas?

Excerpts from Deposition of Paul D. Connor

A Yes.

Q May the Commissioner of Insurance or the State Board of Insurance take action against a company with respect to its issuance of an exempted policy if it deems appropriate?

A Yes. It could take action. Of course, there is no violation in the actual use of a policy which is exempt. I mean the issuance of an exempt policy is not of itself a violation because you have waived the requirement that it be approved.

Q Would it be fair to say that the issuance—that a company who was issuing an exempt policy was doing it with approval and the authority of the State Board of Texas—State Board of Insurance of Texas?

A It isn't truly an approval. If it were, of course, exemption and approval would be synonymous.

Q Maybe I misused the word approval. With the authority and under the authority of the State Board.

A In either case, exempted or approved, the issuing company [18] has a right insofar as the form of the contract is concerned, to use it.

Q Mr. Connor, going back to the exemption order which is Deposition Exhibit 55, in the fourth paragraph, do you recall in particular doing any additional work with respect to determining whether or not the exemption should be withdrawn or extended or just allowed to be carried on for an indefinite period of time?

A I don't have any recollection of it. In these Exhibits I believe there is a suggestion somewhere that the exemption is being granted to cover a rather urgent situation in which bids are being taken to provide the coverage that had been negotiated in the labor agreements. There is a suggestion that the exemption will later be withdrawn if there is a reason to withdraw it, but I have no memory of having followed up.

Excerpts from Deposition of Paul D. Connor

Q Mr. Connor, I suggest to you that the exemption has not been withdrawn. Would that indicate to you that the Commissioner of Insurance or the State Board of Insurance has not found a reason to withdraw it?

A It probably would. That would be the most logical explanation of it not having been withdrawn. Of course, it could be a matter of neglect, departmental neglect, and even the Attorney General—I see that it was referred to the Attorney General. I don't know what [19] action was taken over there. I am not suggesting neglect, but in fairness I must say that the failure to withdraw the exemption would not—it could be accounted for by other reasons than the equivalent of approval.

Q I understand, sir. Mr. Connor, a moment ago I asked you if a policy which was being issued under an exemption was subject to the same regulatory requirements that an approved policy would be subject to. Are you familiar with Article 21.21 of the Insurance Code of the State of Texas which pertains to unfair competition and unfair practices?

A Yes, sir.

Q I hand you a copy of the article or the book and let you look at it. Mr. Connor, during your tenure of some 26 years with the Insurance Commission, was it your experience that Article 21.21 of the Insurance Code was considered by the State Board of Insurance in determining whether or not to approve or disapprove a policy or even to grant an exemption?

A Yes, if a violation of 21.21 was embodied in the policy itself it would be disapproved for that reason.

Q All right, sir. Is Article 21.21 a statutory method of regulating the business of insurance within the State of Texas?

A Yes, sir.

[20] Q Upon whom is the authority conferred to fulfill that regulation?

Excerpts from Deposition of Paul D. Connor

A The Commissioner of Insurance.

Q Would an exempt policy form which is being issued by a company be subject to the provisions of Article 21.21 of the Insurance Code?

A Yes, sir.

Q Mr. Connor, are you familiar with Article 21.21-2 of the Insurance Code which pertains to unfair settlement practices?

A Yes, sir, I am familiar with it. It is a more recent enactment than the period we are talking about, of course.

Q Would a policy form which has been exempted and which is being issued by an insurance company be subject to the regulatory provisions contained in Article 21.21-2 of the Insurance Code?

A In my opinion it would.

Q All right, sir. Now, that particular article pertains to unfair claim settlement practices.

A Yes, sir.

Q Can you tell me, sir, who can take advantage of the provisions in that article? Maybe my question should be who is that article written to protect.

A Well, it is the policyholders' protection in mind. Yes, to protect the policyholder or the beneficiary.

[21] Q More generally would the article be written to protect anyone who might possibly have a claim against an insurance company?

A Yes, a policyholder claimant or policyholder beneficiary claimant. That is correct.

Q Now, Mr. Connor, I think you are familiar with the method of operation of Blue Shield under this particular prescription drug program. Blue Shield contracts with participating pharmacies who agree to sell prescription medication to subscribers of Blue Shield, and Blue Shield agrees to reimburse the participating pharmacies a certain amount for the prescription medicines that are dispensed. Are you familiar with that, sir?

Excerpts from Deposition of Paul D. Connor

A Yes, I am familiar with it, not with great detailed knowledge. I have glanced at the contract.

Q If a participating pharmacy had some form of a grievance against Blue Shield pertaining to its claim sent in under a participating pharmacy agreement, would it be able to take advantage of the provisions of Article 21.21-2?

A The claimant?

Q Yes, sir.

A I feel sure it would.

MR. PULLEN: I will have to object to that. This is getting more ridiculous by the minute. [22] That question is absolutely unlimited as to any type of claim. Certainly it is not the type of claim in the statute that is involved in this case. I am going to have to request that you make your question clear by specifying what type of claim you are referring to.

MR. CHURCH: Your objections are reserved until the time we present it to the Court.

MR. KAISER: Let me make it clear so that Mr. Pullen will understand.

Q As I mentioned to you, Mr. Connor, Blue Shield has contracted with various independent pharmacies, the pharmacies having agreed to furnish prescription medicines to Blue Shield's insured, and Blue Shield in that contract agrees to pay the pharmacies a certain amount for the medication dispensed. After the dispensing of the medication the pharmacist then sends a claim to Blue Shield for reimbursement. Now, my question was if a pharmacist has a grievance that arises out of a claim that it has sent to Blue Shield, and if it wants to take some action because of the claims practices of Blue Shield, could it take shelter in Article 21.21-2?

A The question is whether a pharmacist could, not whether the injured or disabled or sick person could?

Q Yes, sir.

Excerpts from Deposition of Paul D. Connor

A I don't know.

[23] Q Are you familiar with the Rules of Practice and Procedure before the State Board or Insurance and Commissioner of Insurance?

A Yes, sir.

Q I hand you, sir, what has been marked Deposition Exhibit Number 63 and suggest to you, sir, that that is a copy of those rules.

A Yes, sir, I am familiar with them.

Q To your knowledge, Mr. Connor, are exempt policies subject to the provisions of the Rules of Practice and Procedure of the State Board of Insurance?

A Yes, sir.

Q To your knowledge, Mr. Connor—

MR. KAISER: Strike that.

Q Mr. Connor, are exempt policies which are being issued in the State of Texas treated any differently by the State Board of Insurance and the Commissioner of Insurance than—

MR. KAISER: Strike that question. It is confusing.

Q Are exempt policies which have been issued by an individual insurance company treated any differently by the State Board of Insurance than approved policies?

A They are treated the same. There is no difference.

Q Mr. Connor, during your more than 26 years with the State [24] Board of Insurance did you ever have occasion to or participate in the drafting of legislation which ultimately ended up as part of our Insurance Code?

A Yes, sir, during most of my tenure I worked on legislation, insurance legislation and assisted in the drafting of a great deal of it.

Q Does the Insurance Code as it exists today contain much—very much of your work?

A Yes, I think it does. I know it does.

MR. KAISER: I have no further questions.

Excerpts from Deposition of Paul D. Connor

Questions by Mr. Church:

Q I notice, Mr. Connor, that you prepared these Rules for Practice and Procedure, did you not?

A Yes, sir, I did.

MR. CHURCH: Thank you. I have no more questions.

MR. SHADDOX: No questions.

CROSS EXAMINATION

Questions by Mr. Pullen:

Q Mr. Connor, I have some trouble appreciating the difference in operation between a policy form which is approved and one which is exempt. Can you explain to me what the difference is?

A Well, in either case the company wanting to issue the policy could issue it, and, of course, the policy [25] becomes a legal—I mean it becomes a contract between the insurance company and the policyholder. As well as I can explain it, the difference is that the approved form has received the okay or the official stamp of approval of the Commissioner, while in the case of an exempt form he has simply said that, "For reasons which I set forth here I will not approve nor disapprove this form." Incidentally, there are outside of the field we are talking about here, in other fields of insurance, many kinds of insurance contracts, policy forms which are not subject to approval of any authority.

Q What would be some examples of those?

A Policies issued by Farmer Mutual Insurance Companies, a number of policies covering inland marine risks, practically all of the ocean marine risks and policies of that sort.

Q As a practical matter, though, there is no difference in an exemption and an approval.

Excerpts from Deposition of Paul D. Connor

A There is no difference in that each are contracts and that the issuance of that contract, either approved or exempt, is allowed.

Q Is allowed, all right. What criteria, if any, went into a determination to exempt a policy contract rather than approve it?

A In the case that we are discussing here I can only say that [26] the criteria which is set forth in the Exhibits that we have been referring to.

Q You don't recall any other criteria?

A No, sir, I don't.

Q Do you recall any basic policies that was [*sic*] followed during your time with the Insurance Commission or State Board of Insurance as to when an exemption would be granted and when an approval would be granted?

A Only one instance that comes to mind. When the law initially went into effect which required approval under Article 3.42, of a great number of forms which before that enactment had not required approval, when that law went into effect, I believe, in 1957, or thereabouts, the Department at that time issued several exemption orders because of the inability to review the forms. They were forms which had previously been screened to some extent but not subjected to approval under the new law, therefore they were blanketly exempted. Beyond that time I don't recall any criteria specified for approving or exempting.

Q Was it a usual thing for a policy form which had been disapproved to later have an exemption granted on it?

A I don't think it is usual, no.

Q How many instances can you recall where this occurred?

A I don't recall any other instance.

[27] Q In connection with the exemption order were there any discussions with anyone from Blue Cross-Blue

Excerpts from Deposition of Paul D. Connor

Shield or anyone representing those that that you can recall?

A The letter indicates, this Exhibit 56, that there was an understanding with Mr. Philip Overton—he was the representative of Blue Cross at that time and perhaps still does. I don't know.

Q Did you ever have any discussion or correspondence with Steve G. McDonald?

A I don't believe so. I don't recall it.

Q How about Jack Ponder?

A I don't remember that either. I know Jack Ponder very slightly, but I don't recall any correspondence or discussion with him.

Q What about the discrimination in benefits, was that considered a very stringent question with regard to the prepaid prescription coverage?

A I notice that the disapproval order which is Exhibit 53, part of the basis for disapproval was discrimination. I don't know whether it was considered to be very serious or whether it was later decided that it was not discrimination.

Q What was the question under the Texas Antitrust and Antimonopoly Statutes?

A I don't really recall the specific statute or the specific [28] theory under which the antitrust-antimonopoly laws were brought into play. I can recall it only generally.

Q You referred to Deposition Exhibits 54 and 56 which are letters to Crawford Martin, Attorney General of Texas, which I believe you wrote. Is that correct?

A Yes, sir, I did.

Q Looking at Exhibit 54, which is the letter of August 21, '69, that did not request any action by the Attorney General, did it?

A No. I see no request that the Attorney General take action.

Excerpts from Deposition of Paul D. Connor

Q And looking at Deposition Exhibit 56, which is the subsequent letter of October 1, '69, also I believe from you to Crawford Martin, Attorney General, I believe you say, "We are making no opinion request at this time." Is that not correct?

A That's correct.

Q All right, sir. Do you ever recall any subsequent discussions with anyone from the Attorney General's Office with respect to this question?

A No, sir, I don't.

Q Now, the exemption order in the second paragraph says it "shall also apply to any form, identical in content to form CC-OHDS-2," which as I see it, is the first seven pages of Deposition Exhibit 52. Am I correct in that?

[29] A I don't know. The usual way of referring to a form is by the number which appears here on the front left page, and if it was fastened together or submitted as a unit it would include all of it. I don't know.

Q Well, I notice that the last two pages seem [*sic*] to be called PDPA-1 or something as best I can read it. Do you have any recollection whether it was considered that the participating drug pharmacy agreement was part of the drug supplement insurance contract?

A I don't have any recollection, except to note here that the exemption order refers to—describes these as drug service contracts, but I have no independent recollection.

Q All right, sir. Do you know of any place in the Texas Insurance Code where the State Board of Insurance is given jurisdiction over independent pharmacists?

A No, sir.

Q Does the State Board of Insurance have any antitrust or monopoly jurisdiction?

A I don't believe that it has jurisdiction to prosecute antitrust and antimonopoly cases. I know it does not. As

Excerpts from Deposition of Paul D. Connor

would be indicated here, it would not knowingly approve a vehicle by which these laws could be—would be violated.

Q You mentioned earlier, I believe, that you reviewed this [30] file prior to testifying today very briefly. Is that not correct?

A Yes, sir.

Q Was that done at anyone's request?

A Yes, sir, Mr. Kaiser's request.

Q How did that come about? Did he call you on the phone or write to you or see you in person?

A He saw me in person two or three weeks ago.

Q Did he explain what this case was about?

A Briefly, yes, sir.

Q When you left the State Board of Insurance in 1972, did you begin your practice with Flahive and Ogden?

A Yes, sir.

Q What type of practice do you do, Mr. Connor?

A My practice is largely in insurance administrative law.

Q What does that entail?

A The organization of companies, mergers; I am counsel for several companies, equivalent to general counsel for investments, and general corporate work for insurance companies mainly.

Q Do you do any work for Blue Cross or Blue Shield or any of their related companies?

A No, sir.

Q Does your firm?

A I don't believe that the firm does. I am not sure, but I [31] have not done any work for them.

Q Do you represent any companies who do health and accident insurance?

A Yes, sir.

Q What companies?

Excerpts from Deposition of Paul D. Connor

A I have probably—are you speaking of me personally or the firm?

Q You or the firm, either one.

A I would think that our—in the companies which we represent who do—who are authorized to write health and accident insurance, they would be rather extensive in number, maybe fifty companies or more to some degree of representation.

Q What about the rest of the firm's business, how many other people are there in the firm?

A There are eight attorneys.

Q And would it be fair to say that the firm's major practice or a good part of it is defense of claims against insurance companies?

A We do a great deal of that, yes, sir. That is correct. We represent insurance companies as defense attorneys.

Q Is there anything in writing in the form of a memorandum or rule or regulation which the State Insurance Board uses in determining when to issue an exemption order? Are they given any criteria or guidelines?

[32] A I am not aware of any.

Q It is done on a case by case basis?

A That is correct except for the initial exemptions which I discussed earlier.

MR. PULLEN: No further questions.

MR. SHADDOX: No questions.

MR. CHURCH: I have no questions.

MR. KAISER: I have just a couple more.

REDIRECT EXAMINATION

Questions by Mr. Kaiser:

Q Mr. Connor, I believe you testified in response to Mr. Pullen's questions that the State Board of Insurance has no jurisdiction to prosecute antitrust violations. Is that correct?

Excerpts from Deposition of Paul D. Connor

A I am sure that is the law.

Q Does the State Board of Insurance have jurisdiction to regulate the industry of insurance within the State of Texas?

A Yes, sir.

Q Is there specific legislation in the State of Texas and in the Insurance Code of the State of Texas which prescribes, permits or otherwise regulates the insurance industry and authorizes enforcement of penalties for infractions of the State Insurance Code?

A Yes, sir.

[33] Q Is that done under a scheme of what we might call administrative supervision or regulation?

A Yes.

MR. KAISER: No further questions.

MR. PULLEN: No questions.

* * * *

EXCERPTS FROM DEPOSITION OF ROBERT C. McANELLY, DECEMBER 30, 1975

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

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* * * *

[3] DIRECT EXAMINATION

Questions by Mr. Macon:

Q Please state your full name.

A Robert Coleman McAnelly.

Q Mr. McAnelly, were you served with a subpoena requiring you to appear at this deposition?

A I was.

Q What is your residence?

A 2504 Quarry Road in Austin, Texas.

[4] Q By whom are you employed?

A By the Texas State Board of Insurance.

Q What is your present position with the State Board of Insurance?

A Manager of the Credit Life Section, Policy Approval Division, State Board of Insurance.

Q Mr. McAnelly, have you ever had your deposition taken before?

A Yes, in, of course, a different matter.

MR. KAISER: I hope so.

A About two years ago, I guess.

Q Do you understand that you are answering questions under oath and that your testimony under certain instances may be used at the trial of this case?

A I do.

Q Let me introduce everyone here on the record. My name is Larry Macon, seated to my right is Keith Kaiser, and we represent Group Life and Health Insurance Company which throughout this deposition we will refer to as

Excerpts from Deposition of Robert C. McAnelly

Blue Shield. At your immediate right is Mr. William Church who represents Walgreens. Farther to his right is Mr. Joel Pullen who represents the plaintiffs in this case, and in just a moment we expect back Mr. Charles Shaddox who represents Rieger-Medi-Save. Basically for your information this is an anti-trust suit brought by [5] the plaintiffs against Blue Shield, Walgreens, Rieger/Medi-Save and Sommers Drugstores. If during this deposition you don't understand my questions or you would like for me to repeat them, please ask me to either repeat them or explain any aspect of them you do not understand. Do you understand?

A I understand, right.

Q How long have you been employed by the State Board of Insurance?

A Since June 6 of 1956.

Q How long have you held your present position?

A My present position since March of 1970.

Q What position did you hold prior to March, 1970?

A Prior to that date I was supervisor of the Health and Group Life Unit—Health and Group Life Policy Unit of the Life Division. That title was sometimes referred to as supervisor of A. & H. and Group Life Policy Unit.

Q A. & H. would refer to Accident and Health?

A Right.

Q What were your functions and responsibilities in that position?

A I was supervising a unit whose duties were to review and approve or disapprove life and/or health insurance policy forms which were submitted by insurers for approval pursuant to Article 3.42 of the Texas Insurance [6] Code.

Q Are the functions of your unit now being performed by the Policy Approval Division?

A That's correct, yes.

Q Did—

Excerpts from Deposition of Robert C. McAnelly

MR. PULLEN: Excuse me. Which unit are you talking about, his existing one or prior one?

Q The functions of the prior unit, are they now performed by the Policy Approval Division?

A Yes. In effect, this is all the same division. It has been a policy approval operation for a number of years, ever since I have been associated with it, and initially I was involved in policy approval involving all types of life and health policy forms with the exception of individual life. In other words, my particular area covered all group life, all group health, all individual health and group annuity, and when I moved out of that area and into the more specialized area of credit life insurance, my present area, then in effect I remained within the same area of policy approval operation but into a more specialized unit of it.

Q How long have you been involved in Policy Approval?

A Since June 6, 1956.

Q Which is—

A The date that I was employed first by the State Board of [7] Insurance.

Q For what period were you supervisor of the A & H and Group Health Unit?

MR. KAISER: A & H and Group Life.

Q And Group Life?

A It was from late in 1957 as I recall, about November of '57, up until March of 1970.

Q During 1969 and '70 how many people did you supervise in this capacity?

A Let's see. There were three to four people that I was supervising at that time. These people were policy analysts.

Q Would you explain what would happen when a policy of insurance would be submitted to your section for approval, when it is submitted to your section?

Excerpts from Deposition of Robert C. McAnelly

A The mail, as it came in relative to my unit came through my desk. I would then route the submissions to the particular policy analyst that was responsible for that type of a policy. For instance, we had a group life policy analyst, we had individual policy analysts, individual health policy analysts, and we also had one policy analyst who was responsible for forms of mutual assessment type companies, and then we also had one policy analyst who reviewed group health forms, and so having distributed the forms to the particular analysts involved, they would [8] then proceed to analyze, read the form submitted and would reach conclusions as to whether the forms could be approved as not being in violation of any statute, or if they found a violation, then the analyst would write out their objection to the specific provision objected to and would—I would then make up an order—if it were a disapproval I would make up an order specifying the basis for disapproval of that particular form. That order, once prepared was signed by myself and at that time the section manager, Don Odum, and would then go to the commissioner for his signature and this would then become an official order of the commissioner of insurance.

Q Would the same procedure follow when you approved a policy of insurance?

A That is correct. Those forms which could be approved were listed on an order by name of company and by the form number designation and again, following my signature and that of the section manager it then went to the commissioner for his approval.

Q Was every policy that came to your unit either approved or disapproved?

A Normally they would either be approved or disapproved, although in some cases we might have say informal discussion with the submitting insurer, and in some cases the company of its own volition would voluntarily withdraw.

* * * *

Excerpts from Deposition of Robert C. McAnelly

[10] Q Did your unit ever purposefully allow an automatic approval to occur?

A Not purposely, no. Normally it would be dependent on the work load, that we weren't able to get to it.

Q Mr. McAnelly, I hand you what the court reporter has marked as Deposition Exhibit No. 52. Are you familiar with that document?

A Yes.

Q Would you describe it?

A This by its own description is an experience rated group medical-surgical insurance policy, and it is a policy form of Group Life & Health Insurance Company, and it is identified by Form No. CC-OHDS-2, and it bears a stamp indicating disapproval by commissioner's order no. 29701 dated June 18, 1969.

Q Was the policy which has been marked Deposition Exhibit No. 52 submitted to your unit?

A Yes, it was.

Q Did you review it when it was submitted to your unit?

A This is the drug supplement to the policy that I just described. Yes, I did review this form.

Q Did you review the drug supplement itself?

A Yes. As a matter of fact, this particular form is a drug supplement to that prior approved group policy form.

Q But the drug supplement itself was submitted to your unit [11] for approval; is that correct?

A That is correct.

Q Will you turn on Deposition Exhibit 52 to the last two pages? Could you identify the last two pages of Deposition Exhibit 52?

A The last two pages constitute the participating drug pharmacy agreement that was to be drafted and agreed upon between the participating drug pharmacy and Group Life & Health Insurance Company.

Q Was all of Deposition Exhibit 52, including the last two pages, submitted to you as a unit?

A Yes, it was.

Q Do you recall who in your section besides yourself reviewed Deposition Exhibit 52?

A To the best of my recollection, I personally reviewed this form because it was in the nature of an innovation, and I subsequently conferred with Mr. Paul D. Connor who was then our Chief Clerk and Assistant to the Commissioner of insurance, and Mr. Connor at that time also served as legal counsel or legal adviser for policy approval matters for the department—for the State Board of Insurance.

Q As a result of your review did you make a determination about whether or not to approve Deposition Exhibit 52?

A Yes, I did. I raised the objection that it would be in violation of Article—well, Article 21.21, specifically [12] Section 4, Sub-section 7B of the Texas Insurance Code which prohibits unfair discrimination as to rates or benefits provided to a class of people of essentially the same class and the same risk hazard.

Q What was the final result of your determination, that it should be disapproved?

A It was my opinion that the form should be disapproved for that reason, as being—or containing provisions in violation of Article 21-21, Section 4, sub-section 7, paragraph B.

Q As a result of your decision was an official order of the Commissioner of Insurance issued?

A Yes, an official order was issued pursuant to that objection plus another.

Q Who raised the other objection?

A The other objection was raised by Mr. Paul D. Connor to whom I have referred as our assistant to the commissioner. As a matter of fact, the way this evolved

was that having raised my objection as I saw it under insurance law, we then had discussions with Mr. Paul D. Connor, and the ultimate result was that two objections were specified in the disapproval order.

Q Was the end result of your decision the official order that is marked Deposition Exhibit No. 53?

A That is correct.

[13] Q Subsequent to the disapproval which is noted by Deposition Exhibit No. 53, was any further action taken with respect to the policy?

A Yes, there was subsequent discussion, and then subsequent formal action taken by a later issued official order of the commissioner.

Q Is the official order you referred to Deposition Exhibit 55?

A That is correct.

Q What did that order do?

A This order, by its own provisions, it superceded the prior order, Exhibit 53, and exempted this form from the approval requirements of Article 3.42 of the Texas Insurance Code.

Q Did the order nullify and reverse the previous order of the commissioner?

A Yes. The order by its own provisions states "to the extent that this exemption order conflicts with commissioner's Order No. 29701 dated June 18, 1969, Order No. 29701, is superceded."

Q To your knowledge did the exemption order exempt the package which is Deposition Exhibit 52, from anything other than the filing requirements pursuant to Article 3.42?

A It exempted it from the filing requirements and the carrying through of the approval requirement.

[14] Q Did it exempt it from anything other than the filing and the approval?

A No.

Excerpts from Deposition of Robert C. McAnelly

Q Is a company which has a policy that has been exempted pursuant to Article 3.42 still subject to the unfair competition and unfair practices act which is Article 21.21?

A Would you restate that?

Q Okay. If you have a company that has had a policy exempted pursuant to 3.42, is that company still subject to the provisions and prohibitions there contained in Article 21.21, the unfair practices act?

A I would say, yes.

Q Is a company that has an exempted policy still subject to the claims settlement provisions of Article 21.21-2?

MR. PULLEN: With respect to the exempted policy or generally?

Q Generally?

A You said with respect to the claims settlement provisions—

Q Are you familiar with—

A —of Article 21.21.

Q Are you familiar with the unfair claims settlement act?

A I am generally familiar with Article 21.21, yes, unfair practices.

Q There is a section of Article 21.21 that has been designated [15] as -2 which deals with settlement of claims.

A Oh.

Q Are you familiar with that?

A Yes.

Q If a company has a policy that has been exempted under 3.42, is the company still subject to the provisions of this section dealing with unfair claims or unfair settlement of claims?

A I would say, yes.

Q Can an exemption that has been issued pursuant to Article 3.42 be withdrawn by the insurance commissioner?

Excerpts from Deposition of Robert C. McAnelly

A Yes, it may by authority of Article 3.42 itself.

Q As a practical matter, is there really any difference between a policy that has been approved by the insurance commissioner and a policy that has been exempted pursuant to Article 3.42?

A I would say basically there is no difference. It simply means that that form may be legally used.

Q And it may be—

A Whether it has been formally approved or whether it has been exempted.

Q And it may be used in the same manner that an approved form could. Is that correct?

A Right.

* * * *

[20] A In other words, as I see the requirement of Article 3.42, it relates to the authorized use of certain specified policy forms.

Q Yes.

A Okay. And so in effect it says that in order for an insurer to legally use such policy forms, such form must either be affirmatively approved by official action of the Commissioner of Insurance or it must be specifically exempted by official action of the Commissioner of Insurance. Either action, as I see it, leaves the company free to use that form.

Q Are you familiar with the criteria or factors which would be considered in determining whether to let the form be used by virtue of approving it or by virtue of exempting it from the requirement?

A Of course, the normal and most usual procedure is the formal approval of the form.

Q Yes.

A But the exemption is a discretionary thing on the part of the commissioner based upon specific circumstances.

Q Now, what are those circumstances as you understand them?

Excerpts from Deposition of Robert C. McAnelly

A They could vary. For instance, at the time that article 3.42 as presently constituted became effective on August 22nd, '57, the prior article 3.42 had only required [21] the filing of forms but the specific statute that related to specific types of forms, for instance, group life forms, the group life law, article 3.50, had always required approval of such forms, so therefore it was deemed unnecessary when 3.42 came along as revised, and again required approval, it was deemed unnecessary to recall all those group life forms which had already been approved because their specific statute required it, just to comply with this new requirement for approval, so therefore such forms were exempted. That was one of the circumstances where it was deemed unnecessary to reapprove forms which had previously been approved.

Q Were you surprised when the prior disapproval was changed through the exemption order?

A I don't recall that I was surprised because I had been—although I was not in on all of the conferences that led up to this exemption, I was aware that a problem had been raised of the fact that another insurer was currently using a form similar to these that were objected to.

Q What was your objection with regard to the unfair discrimination?

A The objection there, as I saw it, was the possibility of unfair discrimination in benefits as between insureds of the same class by reason of the fact that a particular insured might live in a locale where one of the [22] participating pharmacists may not be available and therefore it would seem to discriminate against him as to benefits as opposed to that insured person who happened to live convenient to a participating pharmacy.

Q All right.

A We have had similar precedent of this type of unfair discrimination by reason of location.

Excerpts from Deposition of Robert C. McAnelly

MR. PULLEN: No further questions. Thank you.
MR. KAISER: We may have one or two more.
MR. SHADDOX: No questions.
MR. CHURCH: No questions.

REDIRECT EXAMINATION

Questions by Mr. Kaiser:

Q Mr. McAnelly, let me ask you, sir, if when a policy form is exempted under article 3.42 and the insurance company begins to issue that particular policy form, is the insurance company during the course of the issuance of that policy still subject to all of the sanctions and prohibitions and regulatory devices set out in the insurance code?

A Yes.

Q During the period of time that an insurance company is issuing a policy which has received an exemption, is it [23] still subject to the continued supervision and regulation by the State Board of Insurance?

A Yes.

Q Mr. McAnelly, is the Commissioner of Insurance given broad discretionary powers in regulating the conduct of insurance companies and their issuance of policies in the state of Texas?

A You say in the regulation of insurance companies and the issuance of policies?

Q Yes, sir. Let me just rephrase the question. Is the Commissioner of Insurance given broad discretionary powers in regulating insurance companies with respect to their issuance of policies in the state of Texas?

A Of course, the commissioner's authority is only in the law, and as relates to the approval of life and health forms, article 3.42 is the discretionary authority of which I am aware.

Excerpts from Deposition of Robert C. McAnelly

Q In article 3.42 does the commissioner have broad discretionary powers?

A I would say yes, as defined by provision E. of article 3.42.

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EXCERPTS FROM DEPOSITION OF DONALD H. BUNNELL, DECEMBER 20, 1975

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

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[3] * * * *

DIRECT EXAMINATION

Questions by Mr. Kaiser:

Q State your name, please, sir.

A Donald H. Bunnell.

Q What is your residence address, Mr. Bunnell?

A 3600-C, Las Colinas, FM2222 Austin, Texas, 78731.

Q By whom are you employed, Mr. Bunnell?

A State Board of Insurance, State of Texas.

Q What is your title, sir?

[4] A I am the Manager of the Company License Section.

Q Mr. Bunnell, have you ever had your deposition taken before?

A Not in this agency.

Q Well, have you had your deposition taken before, ever?

A I have had a deposition on prior work in prior years, different locations.

Q Can you tell me in what connection the deposition was taken?

A They were taken in connection with insurance claims as an adjuster and investigator.

Q By whom were you employed at that time?

A Hammerman & Gainer. They are located in Austin, Texas.

Excerpts From Deposition of Donald H. Bunnell

Q All right, sir.
A They are independent insurance adjusters.

* * * *

[7] Q Mr. Bunnell, you said that you were the Manager of the Company License Section. Is that correct?
A Yes, sir.
Q Can you tell me what your duties are as the Manager of the Company License Section?
A Very basically I am responsible for all of the activities involving the company records and documents for those companies that are licensed in the State of Texas, to include the initial incorporation of the domestic companies, and the documents that are related to the foreign admissions, and if I summarized it in a real brief way I could say that it is a matter of from birth to death of a company, and whether or not this involves later on an amendment or change to their Articles of Incorporation or By-Laws, types of coverage that they may be authorized to write, their applications for them, the areas related to any mergers that are required to be filed with the department, any re-insurance agreements that are required to be filed, other actions that involve those companies [8] with other companies, as I said, the quickest way is to say from birth to death. We currently have over 1700 companies licensed in the State of Texas. In addition to this, we have a number of areas wherein we have to check into the management activities of companies along with their financial conditions, and many of those areas are allied with my work, although we have other specialists who actually are statement analysts and accountants who actually handle that particular phase of it. But the over-all is the activity as far as the records of the companies are concerned and the activities of the companies.

Excerpts From Deposition of Donald H. Bunnell

Q All right, sir. Are the records of the Company License Section maintained under your supervision and control?
A Yes, sir.
Q Are you the custodian of the records maintained in the Company License Section?
A I think in the general definition of custodian I would be considered as the custodian, although I do not actually have that official type of a title. I have other people who work under my supervision and direction who actually are directly responsible for the actual records in certain storage cabinets that we have here in the department.
Q Mr. Bunnell, are you familiar with the corporate organization of Group Life and Health Insurance Company?
[9] A Of Dallas, Texas?
Q Yes, sir.
A Yes, sir, I am familiar with that company to the extent that we consider it as a Chapter 3 type life insurance company under our Code, and I believe that is a stock life insurance company.
Q Can you tell me or just elaborate a little bit on what a Chapter 3 company is?
A Well, a Chapter 3 company is a company which is authorized to be a stock company. The capital and surplus of the company required as a beginning is $100,000 capital and $100,000 surplus at the present time. It is by short version referred to as a stock life company. We have in the neighborhood of twenty-nine or thirty different types of companies, and this is one type of the different types of companies we have in this seventeen hundred plus companies licensed.
Q Now, Mr. Bunnell, would you tell me how a Chapter 3 company is formed?

Excerpts From Deposition of Donald H. Bunnell

A Well, I can give you some general basics on it, but wtihout having—

Q Let me rephrase the question. Would you tell me what a Chapter 3 company is required to do? After they have already gotten their Articles of Incorporation prepared, who do they file them with?

[10] A In the beginning—to answer your question, they file them with the Company License Section, but in the beginning they must have a name reservation and the name be reserved and approved by the department before they can start the corporate papers being filed with us.

Q All right, sir. Now, it is my understanding that the Articles of Incorporation are filed with the State Board of Insurance as opposed to the Secretary of State for a Chapter 3 corporation. It that correct?

A This is correct, and I would add this is true not only for a domestic company but would be what we call a foreign company which is one outside of the State of Texas seeking admission to Texas. We are dealing with this company as a Texas domestic company rather than a foreign company.

Q All right. Is a Chapter 3 company required to comply with the State Insurance Code or with the Texas Business Corporation Act in forming a corporation?

A Both are involved, sir.

Q Does a Chapter 3 company ever have to send any of its Articles of Incorporation or amendments thereto or any of its corporate documents to the Secretary of State?

A I am not aware of their being required to do so. As far as the Secretary of State is concerned, I am not aware of it.

[11] Q After the Articles of Incorporation of a Chapter 3 company are submitted to the Company License Section, what happens then?

Excerpts From Deposition of Donald H. Bunnell

A The documents that are required are sent to our Legal Section for review in accordance with the approved checklist for the incorporation or organization of a new Texas domestic company. The Legal Department has the responsibility from that point until we have a public hearing, recommendation has been made by Commissioner's Order to send those documents to the Texas Attorney-General's Office, and the Texas Attorney-General's Office has certified by affixing his signature and seal on the documents as being approved. Once this is done the Texas Attorney-General's Office returns those documents to Company License Section here and in turn we prepare the final Order to issue a license to the company. There are two instruments that are prepared. One is a Commissioner's Order for the license and the other one is the actual license or Certificate of Authority as is the term that we use.

Q Am I to understand, Mr. Bunnell, that the entire decision as to whether or not to grant a Certificate of Authority to a domestic Chapter 3 company rests completely upon the State Board of Insurance?

A No, sir, that is not correct.

[12] Q Well, pardon me. The State Board of Insurance and the State Attorney-General?

A The two offices, the State Board of Insurance and the Texas Attorney-General's Office both have separate requirements. To my knowledge they are the only two State agencies or offices who are involved in the final decision to issue a Certificate of Authority.

Q All right. Are the Articles—to your knowledge, sir, are the Articles of Incorporation or any amendments ever passed upon by the Secretary of State?

A For a Chapter 3 company or this company, Group Life and Health Insurance Company, I am not aware of any.

Excerpts From Deposition of Donald H. Bunnell

Q All right, sir. I have had two documents marked, one as Deposition Exhibit 64 and the other as Deposition Exhibit 65. Deposition Exhibit 64 is a certified copy of the original Articles of Incorporation of American Life Insurance Company, Fort Worth, Texas, which was filed December 30, 1952, and consists of four pages. Also on Exhibit 64 is an amendment changing the home office to Houston, Texas, filed on April 16, 1956 consisting of five pages. The next item is an amendment filed May 9, 1956, consisting of five pages. The next document is an amendment changing the name and home office to Group Life and Health Insurance Company, Dallas, Texas, filed December 1, 1960, consisting of five pages. The [13] next document is an amendment filed January 29, 1965, consisting of five pages. The last document is an amendment filed January 14, 1974, consisting of five pages.

MR. KAISER: Would all of you stipulate that these are—that these certified copies constitute true and correct copies of the documents contained in the State Board of Insurance Company License Section file?

MR. CHURCH: I will stipulate it.

MR. SHADDOX: So stipulated.

MR. CHURCH: And, Joel Pullen, speak up.

MR. KAISER: Mr. Pullen nodded his head, "Yes."

MR. PULLEN: Nodded, yes.

MR. CHURCH: I wanted him to say "Yes" and Bill Moore to get it.

Q Deposition Exhibit No. 65 is a certified copy of a Certificate of Authority No. 2246 dated December 15, 1960, issued to Group Life and Health Insurance Company, Dallas, Texas, consisting of one page.

MR. KAISER: I would ask that all of Counsel again stipulate that—

MR. CHURCH: I so stipulate.

MR. KAISER: —is a true and correct copy of the Certificate of Authority which is on file in the Company License Section of the State Board of [14] Insurance.

Excerpts From Deposition of Donald H. Bunnell

MR. PULLEN: All right, so stipulated.

MR. SHADDOX: Correct.

Q Mr. Bunnell, I am going to hand you what has been marked as Deposition Exhibit 65, which is a certified copy of the Certificate of Authority of Group Life and Health Insurance Company.

A All right, sir.

Q I will ask you, sir, what an insurance company is authorized to do, once a Certificate of Authority is issued.

MR. KAISER: Let me strike that.

Q I will ask you, sir, what a Chapter 3 insurance company is authorized to do after a Certificate of Authority is issued?

A The company under Chapter 3 is authorized in accordance with the Certificate of Authority, and in this case with Group Life and Health Insurance Company of Dallas, Texas, it was authorized to transact the business of life, health and accident insurance as provided in the provisions of Chapter 3 of our Texas Insurance Code, and as may be either amended or changed or modified by further Board Orders or Board decisions that may become involved in the various regulations or statutory authority that is currently authorized.

Q All right, sir. With respect to Chapter 3 companies, [15] in return for being authorized to transact business of life, health and accident insurance, does a Chapter 3 company subject itself to the regulation and control of the State Board of Insurance?

A Yes, sir, it does.

Q Does the State Board of Insurance, and in particular, the Company License Section, maintain continuing supervision and control and monitoring of the business of a Chapter 3 company?

A Within the definitions of what you mean by supervision, monitoring and control, my answer would be yes. There are certain statutory requirements, and then there

are certain requirements that may come forth that require more frequent review than is required statutorily.

Q What would be the occasions in the Company License Section for you to take any action with respect to Group Life and Health Insurance Company?

A As far as Company License Section itself is concerned, it can be many different things which may result from actions taken in other areas of the department. The most well known or the most discussed area that could occur is if the capital and/or surplus of the company was impaired. This is a means to have action taken against the company, either bring it up to the minimum or if there is some other financial problem which is [16] handled through our examination staff and through our statement analysts, again, this is not directly the Company License responsibility. We are, you might say, at the end of the procedure here after such a fact may have been determined. This is just one of many areas. There may be some question in regard to the management of the company. There are several areas of the department that would be involved. Ours has an interest in this also. So we may have reasons given to us from other areas as to why we would become involved in a public hearing on the company.

Q All right, sir. What statutory provisions or regulatory provisions does the Company License Section utilize in supervising the existence of a Chapter 3 company—the existence and the operation of a Chapter 3 company?

A We are still—the basic statutory requirement is Chapter 3 of the Texas Insurance Code, and, of course, there are certain provisions of Board responsibility, and when I speak of Board I am speaking of the State Board as a three-member Board. They have a separate responsibility above what the Commissioner of Insurance has that is covered in Chapter 1 of the Code.

* * * *

[18] Q Is a duly authorized Chapter 3 company subject to all of the provisions of the Insurance Code of the State of Texas?

A A Chapter 3 company would not be subject to all of the provisions of the Texas Insurance Code. They would be subject to only those provisions in Chapter 3, the Board Orders, Commissioner's Orders or directives that may be applied to Chapter 3 as results from Chapter 1 which is the general administrative chapter. So to give as an example, a Chapter 9 company is a fraternal benefit society, and they are subject to Chapter 9 and Chapter 1 proceedings. A Chapter 22 company is a [19] stipulated premium company, and it is subject to Chapter 22, some portions of Chapter 14 and also Chapter 1 of the Code.

Q Is a Chapter 3 company subject to the provisions of Chapter 21 of the Insurance Code which contains the general provisions?

A That is an area of the Code which I do limited work directly with, but you have reminded me that there is this area of general provisions, and also those which pertain to agents in Chapter 21.

Q All right, sir. Is a Chapter 3 company authorized to transact business of insurance outside of the State of Texas?

A A Chapter 3 domestic company in Texas may operate in any State outside of the State of Texas provided that they meet the requirements of that State.

Q My question is then does the Certificate of Authority which has been marked here as Exhibit 65 limit—as far as the State Board of Insurance is concerned, does it limit where Group Life and Health Insurance Company can transact business?

A Yes, sir.

Q And what are the limitations?

A Authorized to transact business in the State of Texas only.

* * * *

ARTICLES OF INCORPORATION OF GROUP LIFE AND HEALTH INSURANCE COMPANY (WITH AMENDMENTS) ("EXHIBIT 64" TO DEPOSITION OF DONALD H. BUNNELL, DECEMBER 30, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

Articles of Incorporation

277

Form A-179

STATE BOARD OF INSURANCE
STATE OF TEXAS

Nº 14125

IT IS HEREBY CERTIFIED That the instrument which is hereunto attached is a true, full and correct copy of

Articles of Incorporation of GROUP LIFE AND HEALTH INSURANCE COMPANY, Dallas, Texas, and all Amendments thereto as follows:

(1) Original Articles of Incorporation of AMERICAN SAVINGS LIFE INSURANCE COMPANY, Fort Worth, Texas, filed December 30, 1952, consisting of four (4) pages;

(2) Amendment changing the home office to Houston, Texas, filed April 16, 1956, consisting of five (5) pages;

(3) Amendment filed May 9, 1956, consisting of five (5) pages;

(4) Amendment changing the name and home office to GROUP LIFE AND HEALTH INSURANCE COMPANY, Dallas, Texas, filed December 1, 1960, consisting of five (5) pages;

(5) Amendment filed January 29, 1965, consisting of six (6) pages;

(6) Amendment filed January 14, 1974, consisting of five (5) pages;

now on file in and forming a part of the records of the State Board of Insurance.
IN WITNESS WHEREOF, I hereunto subscribe my name and affix the Seal of the State Board of Insurance, in the City of Austin, State of Texas, this

10th day of December, 1975

JOSEPH D. HAWKINS
COMMISSIONER OF INSURANCE

By Patricia L. Gustafson
Patricia L. Gustafson
Assistant Manager
Company License Section

THE ATTORNEY GENERAL
OF TEXAS

Austin 11, Texas

Austin, December 29, 1952

CERTIFICATE

I hereby certify that the attached original Articles of Incorporation of American Savings Life Insurance Company were submitted to me on the 29th day of December, 1952 and, having carefully examined them, I find them to be in accordance with the law of Texas and of the United States.

/s/ Price Daniel
PRICE DANIEL
Attorney General

/s/ Joe S. Moore
Assistant

[SEAL]

[Filed in the Department of Insurance of the State of Texas This 30th Day of Dec. 1952, Commissioner of LIFE INSURANCE. By VL]

THE STATE OF TEXAS,) KNOW ALL MEN
COUNTY OF TARRANT.) BY THESE PRESENTS:

That we, JACK H. HOWARD, N. S. STERN, and JAMES D. MCTAGGART, all citizens of Texas, under and by virtue of the laws of this State, do hereby voluntarily associate

ourselves for the purpose of forming an insurance corporation under and by virtue of the provisions of the Insurance Code of the State of Texas upon the following terms and conditions:

1.

The name of the corporation shall be, —

AMERICAN SAVINGS LIFE INSURANCE COMPANY.

2.

The name and place of residence of each of the incorporators are as follows:

Jack H. Howard	Dallas, Texas
N.S. Stern	Dallas, Texas
James D. McTaggart	Fort Worth, Texas

3.

The location of the home office of said corporation is Fort Worth, Tarrant County, Texas.

4.

The kind or kinds of insurance business said corporation proposes to transact is that of a life, health and accident insurance company as such companies are defined in Article 3.03 of the Texas Insurance Code. Said company shall be a limited capital stock company within the meaning of said Article 3.03 of the Insurance Code of the State of Texas, engaging generally in the business of life, health and accident insurance but with the limitations prescribed in said Article.

5.

The amount of its capital stock is TWENTY FIVE THOUSAND AND NO/100 ($25,000.00) DOLLARS, all

of which stock has been subscribed and paid for. There has also been paid in a surplus of FIVE THOUSAND AND NO/100 ($5,000.00) DOLLARS.

6.

The period of time said corporation is to exist is to be five hundred (500) years.

7.

The amount of said capital stock is divided into twenty five hundred (2500) shares, of the par value of TEN ($10.00) DOLLARS each, and the amount subscribed and paid by each of the incorporators is as follows:

Name	*Shares Subscribed*	*Amount Paid*
Jack H. Howard	833-1/3	$10,000.00
N.S. Stern	833-1/3	$10,000.00
James D. McTaggart	833-1/3	$10,000.00

Attached hereto and marked Exhibit "A" is an affidavit over the signature of said incorporators as evidence of the payment of same.

8.

The number of directors shall be not less than five (5) nor more than nine (9), and the names and residences of those appointed for the first year are as follows:

Jack H. Howard	2830 Clydedale Drive, Dallas, Texas
N.S. Stern	4336 Shenandoah, Dallas, Texas
James D. McTaggart	1211 Continental Life Bldg., Ft. Worth, Tex.
Quin P. Courtney, Jr.	1211 Continental Life Bldg., Ft. Worth, Tex.
R.W. Decker	1211 Continental Life Bldg., Ft. Worth, Tex.

IN WITNESS WHEREOF, we hereunto sign our names this 2nd day of December, 1952.

/s/ Jack H. Howard
JACK H. HOWARD

/s/ N. S. Stern
N. S. STERN

/s/ James D. McTaggart
JAMES D. MCTAGGART

THE STATE OF TEXAS,)
COUNTY OF TARRANT.)

BEFORE ME, the undersigned authority, on this day personally appeared JACK H. HOWARD, N. S. STERN and JAMES D. McTAGGART, known to me to be the persons whose names are subscribed to the foregoing instrument, and also known to me to be citizens of said State, and each acknowledged to me that he executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this 2nd day of December, 1952.

/s/ Vera Hall
(VERA HALL)
Notary Public,
Tarrant County, Texas

[NOTARY SEAL]

THE ATTORNEY GENERAL
OF TEXAS

Austin 11, Texas

Austin, April 13, 1956

CERTIFICATE

I hereby certify that the attached amendment to the Articles of Incorporation of American Savings Life Insurance Company, which was approved by order of the Board of Insurance Commissioners dated April 5, 1956, were submitted to me on the 13th day of April, 1956 and, having examined them as to form only, I find them to be in conformity with the law of this State in that regard.

/s/ John Ben Shepperd
Attorney General

[SEAL]

[Filed in the Department of Insurance of the State of Texas this 16th day of April 1956, Commissioner of LIFE INSURANCE. By L. Wilson]

STATE OF TEXAS
COUNTY OF HARRIS

KNOW ALL MEN
BY THESE PRESENTS

THAT, WHEREAS, at a meeting of the stockholders of the American Savings Life Insurance Company held at 3103 South Main in Houston, Texas, on February 28, 1956, in conformity with the By-Laws thereof, a majority of the stockholders of said Corporation voted to change the location of the home office of said Corporation from

Fort Worth, Tarrant County, Texas, to Houston, Harris County, Texas;

NOW, THEREFORE, we, Dr. R. O. Brennan, Robert C. McKay, Dr. V. L. Jennings, A. N. M. Cravens, and Marshall McDonald, being a majority of the Board of Directors of said Corporation, in compliance with the action of the stockholders aforesaid, do hereby amend the original Articles of Incorporation of said Corporation so as to change the home office of said Corporation from Fort Worth, Tarrant County, Texas, to Houston, Harris County, Texas, so that Article 3 of said Articles of Incorporation shall hereafter read as follows:

The location of the home office of said Corporation is Houston, Harris County, Texas, and we hereby certify such action to the Board of Insurance Commissioners of the State of Texas.

IN TESTIMONY WHEREOF we here unto subscribe our names this 13th day of March, 1956.

/s/ Dr. R. O. Brennan
DR. R. O. BRENNAN

/s/ Robert C. McKay
ROBERT C. MCKAY

/s/ Dr. V. L. Jennings
DR. V. L. JENNINGS

/s/ A. N. M. Cravens
A. N. M. CRAVENS

/s/ Marshall McDonald
MARSHALL MCDONALD

Directors of American
Savings Life Insurance
Company

STATE OF TEXAS
COUNTY OF HARRIS

Before me, a Notary Public in and for said county and state, on this day personally appeared DR. R. O. BRENNAN known to me to be the same DR. R. O. BRENNAN whose name is subscribed to the foregoing instrument and to be a Director of American Savings Life Insurance Company, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this 13th day of March, 1956.

/s/ Alleen Hathorn
Notary Public

[NOTARY SEAL]

STATE OF TEXAS
COUNTY OF HARRIS

Before me, a Notary Public in and for said county and state, on this day personally appeared ROBERT C. McKAY known to me to be the same ROBERT C. McKAY whose name is subscribed to the foregoing instrument and to be a Director of American Savings Life Insurance Company, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this 15th day of March, 1956.

/s/ Alleen Hathorn
Notary Public

[NOTARY SEAL]

STATE OF TEXAS
COUNTY OF TARRANT

Before me, a Notary Public in and for said county and state, on this day personally appeared DR. V. L. JENNINGS known to me to be the same DR. V. L. JENNINGS whose name is subscribed to the foregoing instrument and to be a Director of American Savings Life Insurance Company, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this 14 day of March, 1956.

/s/ Martha Shaw
Notary Public

[NOTARY SEAL]

STATE OF TEXAS
COUNTY OF HARRIS

Before me, a Notary Public in and for said county and state, on this day personally appeared A. N. M. CRAVENS known to me to be the same A. N. M. CRAVENS whose name is subscribed to the foregoing instrument and to be a Director of American Savings Life Insurance Company, and acknowledged to me that she executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this 15th day of March, 1956.

/s/ Alleen Hathorn
Notary Public

[NOTARY SEAL]

Articles of Incorporation

STATE OF TEXAS
COUNTY OF HARRIS

Before me, a Notary Public in and for said county and state, on this day personally appeared MARSHALL McDONALD known to me to be the same MARSHALL McDONALD whose name is subscribed to the foregoing instrument and to be a Director of American Savings Life Insurance Company, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this 13th day of March, 1956.

/s/ Alleen Hathorn
Notary Public

[NOTARY SEAL]

Articles of Incorporation

Minute No.
56 366

OFFICIAL MINUTE

of Meeting

BOARD OF INSURANCE COMMISSIONERS
AUSTIN, TEXAS

Date April 5, 1956

Members present: Voted

J. Byron Saunders
Life Insurance Commissioner, Chairman
Mark Wentz
Fire Insurance Commissioner
Morris Brownlee
Casualty Insurance Commissioner

Subject Considered:

Charter Amendment
AMERICAN SAVINGS LIFE INSURANCE COMPANY
Houston, Texas

General remarks and action taken:

On this date the Board of Insurance Commissioners considered the application of American Savings Life Insurance Company to amend its charter to change its principal place of business from Fort Worth, Tarrant County, Texas, to Houston, Harris County, Texas.

Article 3.05, Texas Insurance Code, does not require a public hearing on such charter amendment. Therefore,

the Board enters this as its order of approval and acceptance of such charter amendment.

/s/ J. Byron Saunders
J. BYRON SAUNDERS
Chairman

/s/ Mark Wentz
MARK WENTZ
Commissioner

/s/ Morris Brownlee
MORRIS BROWNLEE
Commissioner

THE ATTORNEY GENERAL
OF TEXAS

Austin 11, Texas

Austin, May 8, 1956

CERTIFICATE

I hereby certify that the attached amendment to the Articles of Incorporation of American Savings Life Insurance Company, which was approved by order of the Board of Insurance Commissioners dated April 27, 1956, were submitted to me on the 8th day of May, 1956 and, having examined them as to form only, I find them to be in conformity with the law of this State in that regard.

/s/ John B. Shepperd
Attorney General

[Filed in the Department of Insurance of the State of Texas This 9th Day of May 1956, Commissioner of LIFE INSURANCE By L. Wilson.]

[SEAL]

STATE OF TEXAS)
COUNTY OF HARRIS)

KNOW ALL MEN
BY THESE PRESENTS

THAT, WHEREAS, at a meeting of the stockholders of the American Savings Life Insurance Company held at 3103 South Main in Houston, Texas, on March 13, 1956, in conformity with the By-Laws thereof, a majority of the stockholders of said Corporation voted to change the capital stock of said Corporation to 25,000 shares of the par value of One ($1.00) Dollar each:

NOW, THEREFORE, we, Dr. R. O. Brennan, Robert C. McKay, Dr. V. L. Jennings, A. N. M. Cravens, and Marshall McDonald, being a majority of the Board of Directors of said Corporation in compliance with the action of the stockholders aforesaid, do hereby amend the original Articles of Incorporation of said Corporation so as to change the capital stock of said Corporation to 25,000 shares of the par value of One ($1.00) Dollar each, so that Article 6 of said Articles of Incorporation shall hereafter read as follows:

> "The amount of said capital stock is divided into twenty-five thousand (25,000) shares of the par value of One ($1.00) Dollar each",

and we hereby certify such action to the Board of Insurance Commissioners of the State of Texas.

IN TESTIMONY WHEREOF we here unto subscribe our names this 23rd day of March, 1956.

/s/ Dr. R. O. Brennan
DR. R. O. BRENNAN

/s/ Robert C. McKay
ROBERT C. MCKAY

/s/ Dr. V. L. Jennings
DR. V. L. JENNINGS

/s/ A. N. M. Cravens
A. N. M. CRAVENS

/s/ Marshall McDonald
MARSHALL MCDONALD

Directors of American Savings Life Insurance Company

STATE OF TEXAS
COUNTY OF HARRIS

Before me, a Notary Public in and for said county and state, on this day personally appeared DR. R. O. BRENNAN known to me to be the same DR. R. O. BRENNAN whose name is subscribed to the foregoing instrument and to be a Director of American Savings Life Insurance Company, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this 26th day of March, 1956.

/s/ Alleen Hathorn
Notary Public

[NOTARY SEAL]

STATE OF TEXAS
COUNTY OF HARRIS

Before me, a Notary Public in and for said county and state, on this day personally appeared ROBERT C. McKAY known to me to be the same ROBERT C. McKAY whose name is subscribed to the foregoing instrument and to be a Director of American Savings Life Insurance Company, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this 16th day of March, 1956.

/s/ Alleen Hathorn
Notary Public

[NOTARY SEAL]

STATE OF TEXAS
COUNTY OF TARRANT

Before me, a Notary Public in and for said county and state, on this day personally appeared DR. V. L. JENNINGS known to me to be the same DR. V. L. JENNINGS whose name is subscribed to the foregoing instrument and to be a Director of American Savings Life Insurance Company, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this 24th day of March, 1956.

/s/ O. W. White
Notary Public

[NOTARY SEAL]

STATE OF TEXAS
COUNTY OF HARRIS

Before me, a Notary Public in and for said county and state, on this day personally appeared A. N. M. CRAVENS known to me to be the same A. N. M. CRAVENS whose name is subscribed to the foregoing instrument and to be a Director of American Savings Life Insurance Company, and acknowledged to me that she executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this 26th day of March, 1956.

/s/ Alleen Hathorn
Notary Public

[NOTARY SEAL]

STATE OF TEXAS
COUNTY OF HARRIS

Before me, a Notary Public in and for said county and state, on this day personally appeared MARSHALL McDONALD known to me to be the same MARSHALL McDONALD whose name is subscribed to the foregoing instrument and to be a Director of American Savings Life Insurance Company, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this 23rd day of March, 1956.

/s/ Alleen Hathorn
Notary Public

[NOTARY SEAL]

Minute No.
56 476

OFFICIAL MINUTE

of Meeting

BOARD OF INSURANCE COMMISSIONERS
AUSTIN, TEXAS

Date April 27, 1956

Members present: Voted

J. Byron Saunders
Life Insurance Commissioner, Chairman
Mark Wentz
Fire Insurance Commissioner
Morris Brownlee
Casualty Insurance Commissioner

Subject Considered:

Charter Amendment
AMERICAN SAVINGS LIFE INSURANCE COMPANY
Houston, Texas

General remarks and action taken:

On this date, the Board of Insurance Commissioners considered the amendment to charter of American Savings Life Insurance Company to increase their shares of capital stock outstanding to 25,000 at a par value of $1.00 each.

The applicable statutes do not require public hearing on this matter. Therefore, the Board enters this as its order of approval on such charter amendment.

It is further directed that this charter amendment now be referred to the Attorney General for his approval as required by Article 2.03, Section 5, Texas Insurance Code.

/s/ J. Byron Saunders
J. BYRON SAUNDERS
Chairman

/s/ Mark Wentz
MARK WENTZ
Commissioner

/s/ Morris Brownlee
MORRIS BROWNLEE
Commissioner

THE ATTORNEY GENERAL OF TEXAS

Austin 11, Texas

Will Wilson
Attorney General

Austin, November 23, 1960

CERTIFICATE

I hereby certify that the attached Charter Amendment to Articles of Incorporation of American Savings Life Insurance Company, together with all supporting documents, which were heretofore approved by the order of the Commissioner of Insurance dated November 21, 1960, were submitted on the 22nd day of November 1960 and, being examined only as to formal compliance with the Constitution and laws of the State of Texas and not as to solvency or financial condition, is in this respect in conformity with the law of Texas.

/s/ Will Wilson
WILL WILSON
Attorney General

[SEAL]

[Filed with State Board of Insurance of the State of Texas this 1st Day of December 1960, Commissioner of Insurance, By /s/ B. Brown]

ARTICLES OF AMENDMENT
to the
ARTICLES OF INCORPORATION

Pursuant to the provisions of Article 4.04 of the Texas Business Corporation Act, the undersigned corporation adopts the following Articles of Amendment to its Articles of Incorporation, which changes the name of the

corporation, changes the home office of the corporation, and changes the maximum number of Directors of the corporation.

I.

The name of the corporation is American Savings Life Insurance Company.

II.

The following amendments to the Articles of Incorporation were adopted by the shareholders of the corporation on the 4th day of October, 1960:

Article I of the original or amended Articles of Incorporation is hereby amended to read as follows:

> The name of the corporation shall be GROUP LIFE AND HEALTH INSURANCE COMPANY.

Article III of the original or amended Articles of Incorporation is hereby amended to read as follows:

> The location of the home office of said corporation is Dallas, Dallas County, Texas.

Article VIII of the original or amended Articles of Incorporation is hereby amended to read as follows:

> The number of directors shall be not less than five (5) or more than twenty-seven (27).

III.

The number of shares of the corporation outstanding at the time of such adoption was twenty-five thousand (25,000); and the number of shares entitled to vote thereon was twenty-five thousand (25,000).

IV.

The number of shares voted for such amendments were twenty-five thousand (25,000); and the number of shares voted against such amendments were none (0).

DATED this 20th day of October, 1960.

American Savings Life
Insurance Company

By: /s/ L. H. Allen
L. H. ALLEN
Its President

and

By: /s/ W. R. McBee
W. R. MCBEE
Its Secretary

STATE OF TEXAS :
:
COUNTY OF HARRIS :

I, D. M. Johnston, a Notary Public, do hereby certify that on this 20th day of October, 1960, personally appeared before me, L. H. Allen, who declared he is President of the corporation executing the foregoing document, and being first duly sworn, acknowledged that he signed the foregoing document in the capacity therein set forth and declared that the statements therein contained are true and correct.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year before written.

/s/ D. M. Johnston
Notary Public in and for
Harris County, Texas

STATE OF TEXAS :
:
COUNTY OF DALLAS :

I, Judy Johnson, a Notary Public, do hereby certify that on this [Illegible] day of October, 1960, personally appeared before me, W. R. McBee, who declared he is Secretary of the corporation executing the foregoing document, and being first duly sworn, acknowledged that he signed the foregoing document in the capacity therein set forth and declared that the statements therein contained are true and correct.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year before written.

/s/ Judy Johnson
Notary Public in and for
Dallas County, Texas

No. [Illegible]

OFFICIAL ORDER

of the

COMMISSIONER OF INSURANCE

of the

STATE OF TEXAS
AUSTIN, TEXAS

Date Nov. 21, 1960

Subject Considered:

AMERICAN SAVINGS
LIFE INSURANCE COMPANY
Houston, Texas

CHARTER AMENDMENT

General remarks and official action taken:

On this day, came on for consideration by the Commissioner of Insurance, the application for approval of a charter amendment by AMERICAN SAVINGS LIFE INSURANCE COMPANY, Houston, Texas, changing the name of the Company from AMERICAN SAVINGS LIFE INSURANCE COMPANY to GROUP LIFE AND HEALTH INSURANCE COMPANY, changing the home office of the Company from Houston, Harris County, Texas, to Dallas, Dallas County, Texas, and changing the number of directors of the Company to be not less than five (5) nor more than twenty-seven (27).

A public hearing was deemed necessary by the Commissioner of Insurance on the charter amendment, and due and proper notice was given to the Company, and the Company has furnished a publisher's affidavit that the notice of the hearing was published in a newspaper of general circulation in the county of the home office of the Company, and that such notice was published at least ten (10) days prior to such hearing.

On November 17, 1960, a public hearing was held before Joe B. Roberts, Hearing Officer for the State Board of Insurance, at 10:00 A.M. in the Hearing Room of the State Board of Insurance, 815 Brazos Street, Austin, Texas, concerning the proposed charter amendment, and the Company appeared by and through Mr. Phillip R. Overton, Attorney, and offered evidence and testimony in support of the amendment.

Action of the Company stockholders, as required and permitted by Article 3.05 of the Texas Insurance Code and Article 4.02 and 4.04 of the Texas Business Corporation Act, has been evidenced to the Commissioner, and the amendment is properly supported by other required documents and papers.

Based upon the evidence presented to him and the findings and recommendations of the Hearing Officer, the Commissioner finds: (1) the minimum capital and surplus, as required by law, is the bona fide property of the Company; (2) the officers, directors and managing executives have sufficient insurance experience, ability and standing to render success of the Company probable; (3) the Company is acting in good faith. THEREFORE, the Commissioner of Insurance hereby enters this as his ORDER OF APPROVAL of such charter amendment.

It is further directed that, as required by Articles 3.04 and 3.05, Texas Insurance Code, the charter

amendment now be transferred to the Attorney General of the State of Texas for his approval.

/s/ William A. Harrison
WILLIAM A. HARRISON
Commissioner of Insurance

Prepared by:

/s/ Clay Cotten
CLAY COTTEN
Legal Counsel

THE ATTORNEY GENERAL OF TEXAS

Austin 11, Texas

Waggoner Carr
Attorney General

Austin, January 28, 1965

CERTIFICATE

I hereby certify that the attached Charter Amendment to Articles of Incorporation of Group Life and Health Insurance Company, together with all supporting documents, which were heretofore approved by the order of the Commissioner of Insurance, dated January 25, 1965, were submitted on the 25th day of January 1965 and, being examined only as to formal compliance with the Constitution and laws of the State of Texas and not as to solvency or financial condition, is in this respect in conformity with the law of Texas.

/s/ Waggoner Carr
WAGGONER CARR
Attorney General

[SEAL]

[Filed with State Board of Insurance of the State of Texas This 29th Day of January 1965, Commissioner of Insurance, By /s/ [Illegible]]

ARTICLES OF AMENDMENT

to the

ARTICLES OF INCORPORATION

Pursuant to the provisions of Article 4.04 of the Texas Business Corporation Act, the undersigned corporation adopts the following Articles of Amendment to its Articles

of Incorporation, correcting an error made in a previous amendment to the Articles of Incorporation, correcting a conflict that exists between Articles 5 and 7, increasing the amount of capital stock and the number of authorized shares of the corporation, and deleting the description of the corporation as a "limited capital stock company."

I

The name of the corporation is Group Life & Health Insurance Company.

II

The following amendments to the Articles of Incorporation were adopted by the Shareholders of the corporation on September 26, 1964:

An amendment, dated March 13, 1956, purporting to change the capital stock of the Company erroneously designated Article 6 rather than Article 5. This error is hereby corrected.

Article 7 of the Articles of Incorporation is hereby amended by deleting therefrom the following:

"The amount of said capital stock is divided into twenty five hundred (2500) shares, of the par value of TEN ($10.00) DOLLARS each, and the amount subscribed and paid by each of the incorporators is as follows:"

Article 5 of the Articles of Incorporation, as corrected above, is hereby amended to read as follows:

The capital stock of the Company shall be two hundred fifty thousand dollars ($250,000.00), divided into two hundred fifty thousand (250,000) shares of the par value of one dollar ($1.00) each.

Article 4 of the Articles of Incorporation is hereby amended to read as follows:

The kind or kinds of insurance business said corporation proposes to transact is that of a life, health and accident insurance company, engaging generally in the business of life, health and accident insurance pursuant to Chapter 3 of the Texas Insurance Code.

III

The number of shares of the corporation outstanding at the time of such adoption was twenty-five thousand (25,000); and the number of shares entitled to vote thereon was twenty-five thousand (25,000).

IV

The number of shares voted for such amendment was twenty-four thousand nine hundred ninety-six (24,996); and the number of shares voted against such amendment was none (0).

V

The manner in which such amendment effects a change in the amount of stated capital, and the amount of stated capital as changed by such amendment are as follows:

The capital is increased from $25,000.00 to $250,000.00.

Dated December 14, 1964.

GROUP LIFE & HEALTH
INSURANCE COMPANY

By: /s/ E. A. Rowley
E. A. ROWLEY
Its President

By: /s/ Everett C. Fox
EVERETT C. FOX
Its Secretary

Articles of Incorporation

STATE OF TEXAS)
)
COUNTY OF POTTER)

I, Dorothy Gillette, a Notary Public, do hereby certify that on this 14th day of December, 1964, personally appeared before me E. A. Rowley, President of the corporation executing the foregoing document and being first duly sworn, acknowledged that he signed the foregoing document in the capacity therein set forth and declared that the statements therein contained are true.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year before written.

/s/ Dorothy Gillette
Notary Public in and for
Potter County, Texas

My commission expires: June 1965

STATE OF TEXAS)
)
COUNTY OF DALLAS)

I, [——Illegible——], a Notary Public, do hereby certify that on this 21st day of December, 1964, personally appeared before me Everett C. Fox, Secretary of the corporation executing the foregoing document, and being first duly sworn, acknowledged that he signed the foregoing document in the capacity therein set forth and declared that the statements therein contained are true.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year before written.

/s/ [Illegible]
Notary Public in and for
Dallas County, Texas

My commission expires: June 1965

Articles of Incorporation

No. 17823

OFFICIAL ORDER

of the

COMMISSIONER OF INSURANCE

of the

STATE OF TEXAS
AUSTIN, TEXAS

Date Jan. 25, 1965

Subject Considered:

GROUP LIFE AND HEALTH
INSURANCE COMPANY

Dallas, Texas

CHARTER AMENDMENT

General remarks and official action taken:

On this day, came on for consideration by the Commissioner of Insurance, an amendment to the charter of GROUP LIFE AND HEALTH INSURANCE COMPANY, Dallas, Texas, increasing its capital from TWENTY-FIVE THOUSAND DOLLARS ($25,000) divided into Twenty-five Thousand (25,000) shares of stock of the par value of ONE DOLLAR ($1.00) per share to TWO HUNDRED FIFTY THOUSAND DOLLARS ($250,000) divided into Two Hundred Fifty Thousand (250,000) shares of stock of the par value of ONE DOLLAR ($1.00) per share, by declaring a nine-for-one (9 for 1) stock dividend and transferring TWO HUNDRED TWENTY-FIVE THOUSAND DOLLARS ($225,000) from [illegible] to capital; correcting an error made in a previous amendment; correcting a conflict between Ar-

ticles 5 and 7; and deleting the description of the compeny as a "limited capital stock company."

A public hearing was deemed necessary by the Commissioner of Insurance on the charter amendment, and due and proper notice was given to the company, and the company has furnished a publisher's affidavit that the notice of the hearing was published at least ten (10) days prior to the hearing in a newspaper of general circulation in the county of the home office of the company.

On January 22, 1965, a public hearing was held before Joe B. Roberts, Hearing Officer for the State Board of Insurance, in the offices of the State Board of Insurance, 1110 San Jacinto, Austin, Texas, concerning the proposed charter amendment, at which hearing representatives of the company appeared and offered evidence and testimony in support of the amendment.

Action of the Board of Directors and the stockholders of the company, as required and permitted by Article 3.05 of the Texas Insurance Code and Articles 4.02 and 4.04 of the Texas Business Corporation Act, has been evidenced to the Commissioner of Insurance, and the amendment is properly supported by other required documents and papers.

Based upon the evidence and testimony presented at the hearing and the findings and recommendations of the Hearing Officer, the Commissioner finds: (1) the minimum capital and surplus, as required by law, is the bona fide property of the company; (2) the officers, directors and managing executives have sufficient insurance experience, ability and standing to render success of the company probable; (3) the company is acting in good faith. THEREFORE, the Commissioner of Insurance hereby enters this as his ORDER OF APPROVAL of such charter amendment.

It is further ordered that, as required by Articles 3.04 and 3.05, Texas Insurance Code, the charter amendment now be referred to the Attorney General of this State for his approval.

/s/ J. N. Nutt
J. N. NUTT
Commissioner of Insurance

Prepared by:

/s/ P. Frank Lake
P. FRANK LAKE
Legal Counsel

Articles of Incorporation

THE ATTORNEY GENERAL OF TEXAS

Austin, Texas 78711

John L. Hill
Attorney General

Austin, January 3, 1974

CERTIFICATE

I hereby certify that the attached Charter Amendment to Articles of Incorporation of Group Life & Health Insurance Company, together with all supporting documents, which were heretofore approved by the Order of the Commissioner of Insurance, dated December 14, 1973, were submitted on the 18th day of December, 1973 and, being examined only as to formal compliance with the Constitution and laws of the State of Texas and not as to solvency or financial condition, is in this respect in conformity with the law of Texas.

/s/ John L. Hill
JOHN L. HILL
Attorney General

[SEAL]

[Filed with State Board of Insurance of the State of Texas This 14th Day of January 1974, Commissioner of Insurance, By SR]

Articles of Incorporation

ARTICLES OF AMENDMENT

to the

ARTICLES OF INCORPORATION

Pursuant to the provisions of Article 3.05 and Article 3.04 of the Insurance Code of the State of Texas, the undersigned Corporation adopts the following Articles of Amendment to its Articles of Incorporation, increasing the amount of capital stock and the number of authorized shares of the Corporation.

I

The name of the Corporation is Group Life & Insurance Company.

II

The following amendments to the Articles of Incorporation were adopted by the Shareholders of the Corporation on September 29, 1973:

"Article 5 of the Articles of Incorporation, as amended, is hereby amended to read as follows:

The capital stock of the Company shall be one million dollars ($1,000,000.00), divided into one million (1,000,000) shares of the par value of one dollar ($1.00) each."

III

The number of shares of the Corporation outstanding at the time of such adoption was two hundred fifty thou-

[Filed with State Board of Insurance of the State of Texas This 14th Day of January 1974, Commissioner of Insurance, By SR]

sand (250,000); and the number of shares entitled to vote thereon was two hundred fifty thousand (250,000).

IV

The number of shares voted for such amendment was two hundred forty nine thousand eight hundred eighty three (249,883); and the number of shares voted against such amendment was none (0).

V

The manner in which such amendment effects a change in the amount of stated capital, and the amount of stated capital as changed by such amendment are as follows:

The capital is increased from $250,000.00 to $1,000,-000.00.

Dated December 4, 1973.

GROUP LIFE & HEALTH
INSURANCE COMPANY

By: /s/ Tom L. Beauchamp, Jr.
TOM L. BEAUCHAMP, JR.
Its President

By: /s/ Boone Powell
BOONE POWELL
Its Secretary

STATE OF TEXAS)
)
COUNTY OF DALLAS)

I, Linda Jean Arnold, a Notary Public, do hereby certify that on this 4th day of December, 1973, personally appeared before me Tom L. Beachamp, Jr., President of

the corporation executing the foregoing document and being first duly sworn, acknowledged that he signed the foregoing document in the capacity therein set forth and declared that the statements therein contained are true.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year before written.

/s/ Linda Jean Arnold
Notary Public in and for
Dallas County, Texas

My commission expires: June 1, 1975

STATE OF TEXAS)
)
COUNTY OF DALLAS)

I, Linda Jean Arnold, a Notary Public, do hereby certify that on this 4th day of December, 1973 personally appeared before me Boone Powell, Secretary of the corporation executing the foregoing document, and being first duly sworn, acknowledged that he signed the foregoing document in the capacity therein set forth and declared that the statements therein contained are true.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year before written.

/s/ Linda Jean Arnold
Notary Public in and for
Dallas County, Texas

My commission expires: June 1, 1975

Articles of Incorporation

No. 42297

OFFICIAL ORDER

of the

COMMISSIONER OF INSURANCE

of the

STATE OF TEXAS
AUSTIN, TEXAS

Date Dec. 14, 1973

Subject Considered:

GROUP LIFE & HEALTH INSURANCE COMPANY
Dallas, Texas

CHARTER AMENDMENT

General remarks and official action taken:

On this day, came on for consideration by the Commissioner of Insurance, an amendment to the charter of GROUP LIFE & HEALTH INSURANCE COMPANY, Dallas, Texas, increasing its capital from TWO HUNDRED FIFTY THOUSAND DOLLARS ($250,000) divided into Two Hundred Fifty Thousand (250,000) shares of stock with a par value of ONE DOLLAR ($1.00) per share to ONE MILLION DOLLARS ($1,000,000) divided into One Million (1,000,000) shares with a par value of ONE DOLLAR ($1.00) per share by transfer of SEVEN HUNDRED FIFTY THOUSAND DOLLARS ($750,000) from earned surplus to capital and declaring a stock dividend.

Since the amendment involves only a stock dividend by means of a lawful transfer from surplus to capital, a hearing was not deemed by the Commissioner to be necessary.

Articles of Incorporation

Action of the Board of Directors and the stockholders of the company, as required and permitted by Article 3.05 of the Texas Insurance Code and Articles 4.02 and 4.04 of the Texas Business Corporation Act, has been evidenced to the Commissioner of Insurance and the amendment is properly supported by other required documents and papers.

Based upon the evidence presented to him, the Commissioner of Insurance hereby enters this as his ORDER OF APPROVAL of such charter amendment.

It is further directed that, as required by Articles 3.04 and 3.05 of the Texas Insurance Code, the charter amendment now be referred to the Attorney General of the State of Texas for his approval.

/s/ Clay Cotten
CLAY COTTEN
Commissioner of Insurance

by /s/ Don B. Odum
DON B. ODUM
Deputy Commissioner

Prepared by:

/s/ Jeff W. Autrey
JEFF W. AUTREY
Attorney

CERTIFICATE OF AUTHORITY NO. 2246 ISSUED TO GROUP LIFE AND HEALTH INSURANCE COMPANY, DATED DECEMBER 15, 1960 ("EXHIBIT 65" TO DEPOSITION OF DONALD H. BUNNELL, DECEMBER 30, 1975)

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

Certificate of Authority

Form A-119

STATE BOARD OF INSURANCE
STATE OF TEXAS

Nº 14124

IT IS HEREBY CERTIFIED That the instrument which is hereunto attached is a true, full and correct copy of

Certificate of Authority No. 2246 dated December 15, 1960, issued to GROUP LIFE AND HEALTH INSURANCE COMPANY, Dallas, Texas, consisting of one (1) page;

now on file in and forming a part of the records of the State Board of Insurance.
IN WITNESS WHEREOF, I hereunto subscribe my name and affix the Seal of the State Board of Insurance, in the City of Austin, State of Texas, this

10th day of December, 1975

JOSEPH D. HAWKINS
COMMISSIONER OF INSURANCE

By Patricia L. Gustafson
Patricia L. Gustafson
Assistant Manager
Company License Section

Certificate of Authority

STATE OF TEXAS
STATE BOARD OF INSURANCE

Certificate No. 2246 Company No. 01-36770

CERTIFICATE OF AUTHORITY

THIS IS TO CERTIFY THAT

GROUP LIFE AND HEALTH INSURANCE COMPANY
DALLAS, TEXAS

has complied with the laws of the State of Texas applicable thereto and is hereby authorized to transact the business of

Life; Health and Accident

insurance within the State of Texas. This Certificate of Authority shall be in full force and effect until it is revoked, canceled or suspended according to law.

IN TESTIMONY WHEREOF, witness my hand and seal of office at Austin, Texas, this 15th day of December, A. D. 1960.

Edwin A. Harrison
COMMISSIONER OF INSURANCE

TEXAS ATTORNEY GENERAL OPINION NO. WW-1475, DATED DECEMBER 11, 1975 ("APPENDIX I" TO BRIEF OF APPELLEE GROUP LIFE AND HEALTH INSURANCE COMPANY, SEPTEMBER 24, 1976)

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

APPENDIX I

THE ATTORNEY GENERAL OF TEXAS
AUSTIN, TEXAS 78711

JOHN L. HILL
ATTORNEY GENERAL
STATE OF TEXAS
COUNTY OF TRAVIS

I, John L. Hill, Attorney General of Texas, hereby certify that the attached is a true and correct copy of the opinion numbered W W 1475 dated December 11, 1962 written to Mr. William A. Harrison, by Dudley D. McCalla, Assistant, as it appears in the records of this office.

Given under my hand and seal of office this 2nd day of January, 1976.

/s/ John L. Hill
Attorney General

THE ATTORNEY GENERAL OF TEXAS
AUSTIN 11, TEXAS

December 11, 1962

Will Wilson
Attorney General

[This Opinion Affirms Opinion #O-4986-A]

Mr. William A. Harrison
Commissioner of Insurance
International Life Building
Austin 14, Texas

Opinion No. WW-1475

Re: Whether, under the facts stated, Prepaid Prescription Plan, Inc. would be engaging in the business of insurance in furnishing the prescription service required by its service agreements and pharmacy contracts, and related questions.

Dear Mr. Harrison:

You have asked our opinion as to whether or not the business proposed to be conducted by Prepaid Prescription Plan, Inc., is an insurance business. In this connection you point to Attorney General's Opinion No. O-4986-A dealing with a somewhat similar problem and ask whether or not it is still in effect and, if so, whether or not it is correct.

In your request you outline the facts to be considered as follows:

"The Prepaid Prescription Plan, Inc., is a domestic corporation chartered August 4, 1959, under the Texas Business Corporation Act. The Purpose Clause of its Articles of Incorporation provides as follows:

'ARTICLE THREE: The purposes for which the corporation is organized are:

To establish, maintain and operate a prepaid prescription plan or plans whereby prescriptions, either oral or written by duly licensed physicians, may be dispensed by duly licensed pharmacists to individuals, either singly or in groups, who become subscribers thereto:

And in furtherance thereof to enter into contracts with duly licensed pharmacists who are authorized to dispense prescriptions in compliance with the laws of the state in which they do business, whereby such pharmacists agree to provide such prescription service to its subscribers.'

"Membership for a subscriber and/or his dependents is available on a group plan or a pay direct plan upon making application for enrollment on an application form furnished by the company, payment of service fees, and upon acceptance of such application by the company and the issuance of Service Agreement. Membership for a pharmacy in the plan may be obtained by submitting application on a form furnished by the company, payment of membership fee, and execution of Pharmacy Contract. Copies of both type applications and a copy of the Service Agreement and Pharmacy Contract are enclosed herewith for your information as to the exact terms of these instruments.

"The Prepaid Prescription Plan, Inc., is a stock company with the stockholders being the owners of the corporation and entitled to receive profits upon their investment in the stock.

"For and in the consideration of the payment of the monthly service fee provided for in the Service

Agreement a subscriber, after obtaining a legal prescription from a licensed physician, may have the prescription filled by any Member Pharmacy and pay one-third or one-half of the prescription selling price according to the Service Agreement. Prescriptions may be obtained from other than a Member Pharmacy only under certain conditions as set out in the Service Agreement after securing approval of the pharmaceutical director of the company. The company pays directly to the Member Pharmacy the two-thirds or one-half the price of the prescription, as the case may be, which is computed and based upon a schedule of prices as provided for in the Pharmacy Contract. The "prescription selling price" upon which the subscriber's one-third or one-half is computed may be different from the price upon which the company's two-thirds or one-half is computed.

> "The Prepaid Prescription Plan, Inc., acts as an agent for the subscriber and for the member pharmacist but specifically assumes no liability for the performance of the Member Pharmacy."

Insurance has been defined in *Ware* v. *Heath*, 237 S.W.2d 362, (Civ. App. 1951), as: "An undertaking by one party to protect the other party from loss arising from named risks, for the consideration and upon the terms and under the conditions recited" citing Couch's Cyclopedia of Insurance Law, Vol. I, page 2. As stated in *National Auto Service Corporation* v. *State*, 55 S.W.2d 209, (Civ. App. 1932, error dism.): "Whether or not a contract is one of insurance is to be determined by its purpose, effect, contents, and import, and not necessarily by the terminology used, and even though it contain declarations to the contrary. . ." We have concluded that under the facts presented Prepaid Prescription Plan, Inc., hereinafter referred to as the corporation, will be conducting an insurance business.

Examining the contracts furnished us in connection with the opinion request, it can be seen that the benefit to the holder of the service agreement is the obtaining of prescription drugs at a reduced rate, the difference between the amount paid by the subscriber to the pharmacy and the actual sale price being paid to the pharmacist by the corporation.[1] The risk insured against is the possibility that the subscriber's doctor, during the period covered by the service agreement, might see fit to prescribe drugs for his treatment, the filing of which prescriptions would entail an expenditure by the subscriber. In the event of serious illness to the subscriber, he conceivably could be financially unable to purchase the necessary drugs at the current market price. After entering into the service agreement in question, a portion of this risk is distributed to the corporation, for it has agreed (by virtue of the contract between it and the subscriber and between it and the member pharmacy) in consideration of the monthly payment of $1.50 or $1.60 (depending on whether or not a group or an individual is a contracting party) to reimburse a member pharmacy a portion of the price of each prescription filled by the pharmacy for the subscriber. The contingency upon which the payment rests is the filling by the pharmacy of a prescription written by a doctor and submitted to the pharmacy by a subscriber to the Plan. It will be noted that the pharmacy takes no risk. It is completely reimbursed, partly by the subscriber and partly by the corporation—in some respects analogous to deductible hospitalization policies. On the other hand the corporation, organized for profit, is gambling that its cost for prescriptions filled for its subscribers will be less than the amount taken in through the monthly payments.

---

[1] As pointed out in your opinion request, the prescription selling price upon which the subscriber's payment is computed may be different from the price upon which the corporation's payment is computed. This, however, is not material to the question presented.

We can find no cases in this or other jurisdictions passing upon arrangements exactly the same as that herein involved. It resembles in some respects and is presumably based upon medical plans previously passed upon by the courts of certain other jurisdictions, primarily the group health or group medical plans which came into vogue during the depression. The earliest case in this general field is *State ex rel. Fishbach* v. *Universal Service Agency*, 151 Pac. 768, (Wash. Sup. 1915), which was an action by the insurance commissioner of the State of Washington to forfeit the charter of the Universal Service Agency for doing an insurance business without complying with the insurance regulations. The agency entered into contracts with a pharmacist, a doctor, a grocer, and a shoe dealer, the dealers contracting to sell their products at a fixed rate or a fixed discount and the doctor contracting to render medical service for a fixed consideration. The agency also entered into contracts with individuals for the fixed sum of $15.00 per year plus $5.00 for each child covered by the agreement. The products purchased from the dealers were paid for by the individuals purchasing same and the doctor's compensation was a fixed amount out of each membership fee and did not vary with the treatments rendered. The agency assumed no liability for breach of the contract by the doctor or the dealers. The court held that the agency was not in the insurance business because it was insuring against no peril. It can be seen that the arrangement is not the same as that passed upon in this opinion, for the agency obviously assumed no risk that the payments it was called upon to make would exceed the amount which it was taking in from the contract holders.

There are also in existence a group of opinions dealing with group medical plans which are epitomized by the opinions in *California Physicians' Service* v. *Garrison*, 172 P.2d 4, (Cal. Sup. 1946), 167 ALR 306, and *Jordan* v. *Group Health Association*, 107 F.2d 239, U. S. Court

of Appeals, (1939). In both, the formation of the particular type of corporation involved was authorized by statute, both were non-profit and both encompassed group service only. In the *Garrison* case the subscriber's dues amounted to $1.70 (male) and $2.00 (female) a month. The doctors contracted with the service to make available their medical services in return for a payment on a unit basis, i.e., a pro rata distribution *of the dues collected for the month*, depending upon the amount of service which they rendered. In the *Jordan* case, the doctors were paid a fixed annual compensation. In both cases the business was held not to be insurance in nature. As pointed out in the *Jordan* opinion, the corporation assumed no risk and acted only as an agent. If any risk was assumed it was assumed by the doctor. There was no possibility in either case that the cost to the service or group association for the services rendered by the doctors would exceed the amount taken in in monthly dues.

To the same effect is the case of *Commissioner of Banking and Insurance* v. *Community Health Service*, Court of Errors, New Jersey, 30 A.2d 44 (1943). The stipulated facts in that case were to the effect that the defendant corporation contracted with doctors for one year periods for fixed consideration the amount of which varied with the number of individual contract holders but not with the amount of service rendered. The court held on the authority of the *Fishback* case that this was not an insurance business. Of interest to the question before us is the fact that the state contended that the amount of compensation to be paid to the doctor depended upon and would vary with the amount of services rendered regardless of the amount of dues taken in. The court clearly pointed out that it had been stipulated that the compensation was fixed and that the amount of the service rendered would not affect in any way the compensation paid by the service to the doctor. The converse of that situation, of course, is the one with which we are dealing.

Even in the group health field, however, some jurisdictions have held these arrangements to constitute insurance. This is true in the case of *Cleveland Hospital Service Association* v. *Ebright*, Court of Appeals of Ohio, 45 N.E.2d 157, affirmed by the Supreme Court of Ohio, 49 N.E.2d 929 (1943), even though the particular type of corporation was specifically authorized by statute. In that case the amount to be paid to the hospital by the Service Association varied with the amount of service rendered. The opinion reads in part as follows:

> "The advantage to the subscriber, if he invokes the benefits of his contract, requires payment in money which is definitely measured by the extent of service rendered to the subscriber by the hospital to which he elects to go. It is payable upon a contingency, namely, that it is certified by his attending physician that the subscriber requires hospitalization . . . . The contract, in probability, is not to indemnify the subscriber because the hospital which he selects does not extend credit to him and, therefore, there is no primary liability on his part which would be essential to make the service association an indemnifier. The amount which is paid by the subscriber is a charge based upon an actuarial determination of the probable risk incurred in issuing the contract, although that which is provided the subscriber upon the happening of a contingency is so far as he is concerned, service, yet it is measured by a money consideration payable to the hospital because of the rendering of that service to the subscriber on behalf of the plaintiff association."

The group of cases holding that group medical service contracts do not constitute insurance have been attacked insofar as the legal soundness of their reasoning is concerned by law review articles which are, however, favorable to the concept of group health service. For example, the writer in 53 Yale L.J. 162 speaking of the *Jordan* case criticizes the failure of the court "to recognize the underlying risk—distribution function of prepayment—to insure the potential patient against the unpredictable occurrence of sickness." Likewise, in 52 Harvard Law Review 809 appears the following: "And while the distinction between contracts for services and contracts of insurance is sometimes shadowy, it seems clear, that in the case of cooperative health associations, indemnification against medical cost rather than the unique services of the physician is the principal object of the relationship."

These principles seem even more applicable to a corporation for profit of the type with which we are here concerned. We, therefore, conclude that the plan of operation intended to be followed by Prepaid Prescription Plan, Inc., would involve the doing of an insurance business in this state.

This opinion conflicts in no way with the holding in Opinion No. O-4986-A. The facts which were at that time before this office and which are revealed in the opinion itself, show that the health service was of the cooperative type, squarely within the holding of the *Jordan* case above cited. We, therefore, affirm the holding of that opinion.

Texas Attorney General Opinion

SUMMARY

Under the facts stated, Prepaid Prescription Plan, Inc., would be engaging in the business of insurance, in furnishing the prescription service required by its service agreements and pharmacy contracts.

Very truly yours,

WILL WILSON
Attorney General of Texas

By /s/ Dudley D. McCalla
DUDLEY D. MCCALLA
Assistant Attorney General

DDM:ms

APPROVED:

OPINION COMMITTEE:

W. V. Geppert, Chairman
Vernon O. Teofan
J. Gordon Zuber
Bob E. Shannon

REVIEWED FOR THE ATTORNEY GENERAL BY:

Leonard Passmore

Supreme Court, U. S.
FILED
FEB 3 1978
MICHAEL RODAK, JR., CLERK

In the

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY a/k/a BLUE SHIELD and/or BLUE CROSS-BLUE SHIELD OF TEXAS, WALGREEN TEXAS COMPANY, THE SOMMERS DRUG STORES COMPANY, RIEGER/MEDI-SAVE PHARMACIES, INC. d/b/a GIBSONS PHARMACY,

Petitioners,

v.

ROYAL DRUG COMPANY, INC. d/b/a ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, BLAUSER'S PHARMACY, INC., PARKERS PHARMACY, INC., CRAIG BELL d/b/a BELL PHARMACY, GEORGE STONE d/b/a OLMOS PHARMACY, HIGHLAND HILLS PHARMACY, INC., ECONDOSE SYSTEMS, INC. d/b/a MEDICAL CENTER PHARMACY, GUSTAVE HNCIR d/b/a TURNERS PHARMACISTS, CARLOS DIAZ d/b/a VALLEY VIEW PHARMACY, ALFRED SANGALLI d/b/a STAR DRUG STORE, BLANCO PHARMACY, INC., BLANCO SOUTHSIDE PHARMACY, INC., DAN PARADA d/b/a DAN'S PHARMACY, RODOLFO L. DAVILA, INC. d/b/a DAVILA PHARMACY, DELLMAR PHARMACIES, INC. d/b/a DELLMAR PHARMACY #4, RONG, INC. d/b/a ECONOMY PHARMACY #1, ZARZAMORA PHARMACY, INC., and WHITE CROSS PROFESSIONAL PHARMACY, INC. d/b/a WHITE CROSS #1 and d/b/a WHITE CROSS #4

Respondents.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

JOEL H. PULLEN
STEPHEN F. LAZOR
TINSMAN & HOUSER, INC.
1900 National Bank of
Commerce Building
San Antonio, Texas 78205
(512) 225-3121
Attorneys for Respondents

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Statutes

McCarran-Ferguson Act, §§ 1, 2, 3(b), 15 U.S.C. §§ 1011, 1012, 1013(b) (1970) ..... *passim*

Sherman Act, § 1, 15 U.S.C. § 1 (Supp. 1977) 6, 10

In the

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY a/k/a BLUE SHIELD and/or BLUE CROSS-BLUE SHIELD OF TEXAS, WALGREEN TEXAS COMPANY, THE SOMMERS DRUG STORES COMPANY, RIEGER/MEDI-SAVE PHARMACIES, INC. d/b/a GIBSONS PHARMACY,

Petitioners,

v.

ROYAL DRUG COMPANY, INC. d/b/a ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, BLAUSER'S PHARMACY, INC., PARKERS PHARMACY, INC., CRAIG BELL d/b/a BELL PHARMACY, GEORGE STONE d/b/a OLMOS PHARMACY, HIGHLAND HILLS PHARMACY, INC., ECONDOSE SYSTEMS, INC. d/b/a MEDICAL CENTER PHARMACY, GUSTAVE HNCIR d/b/a TURNERS PHARMACISTS, CARLOS DIAZ d/b/a VALLEY VIEW PHARMACY, ALFRED SANGALLI d/b/a STAR DRUG STORE, BLANCO PHARMACY, INC., BLANCO SOUTHSIDE PHARMACY, INC., DAN PARADA d/b/a DAN'S PHARMACY, RODOLFO L. DAVILA, INC. d/b/a DAVILA PHARMACY, DELLMAR PHARMACIES, INC. d/b/a DELLMAR PHARMACY #4, RONG, INC. d/b/a ECONOMY PHARMACY #1, ZARZAMORA PHARMACY, INC., and WHITE CROSS PROFESSIONAL PHARMACY, INC. d/b/a WHITE CROSS #1 and d/b/a WHITE CROSS #4

Respondents.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

ROYAL DRUG COMPANY, INC. d/b/a ROYAL PHARMACY OF CASTLE HILLS AND DISCO PRESCRIPTION PHARMACY, BLAUSER'S PHARMACY, INC., PARKERS PHARMACY, INC., CRAIG BELL d/b/a BELL PHARMACY, GEORGE STONE d/b/a OLMOS PHARMACY, HIGHLAND HILLS PHARMACY, INC., ECONDOSE SYSTEMS, INC. d/b/a MEDICAL CENTER PHARMACY, GUSTAVE HNCIR d/b/a TURNERS PHARMACISTS, CARLOS DIAZ d/b/a VALLEY VIEW PHARMACY, ALFRED SANGALLI d/b/a STAR DRUG STORE, BLANCO PHARMACY, INC., BLANCO SOUTHSIDE PHARMACY, INC., DAN PARADA d/b/a DAN'S PHARMACY, RODOLFO L. DAVILA, INC. d/b/a DAVILA PHARMACY, DELLMAR PHARMACIES, INC. d/b/a DELLMAR PHARMACY #4, RONG, INC. d/b/a ECONOMY PHARMACY #1, ZARZAMORA PHARMACY, INC., and WHITE CROSS PROFESSIONAL PHARMACY, INC. d/b/a WHITE CROSS #1 and d/b/a WHITE CROSS #4 oppose the Petition for a Writ of Certiorari (Petition) filed by Group Life and Health Insurance Company, Rieger/Medi-Save Pharmacies, Inc., Walgreen Texas Co. and The Sommers Drug Stores Company.

OPINION BELOW

The opinion of the United States District Court for the Western District of Texas is annexed hereto as Appendix A ("App. A") and is reported at 415 F. Supp. 343. The opinion of the United States Court of Appeals for the Fifth Circuit is annexed hereto as Appendix B ("App. B") and is reported at 556 F. 2d 1375.

QUESTIONS PRESENTED

In their Petition, Petitioners have posed the following as the question for review:

> [W]hether the "business of insurance" includes direct contractual arrangements between an insurer and third parties to provide benefits owed to the insurer's policyholders when such contractual arrangements are required by the policy of insurance. Petition at 2.

Respondents respectfully submit that the global question articulated by Petitioners was not the question decided by the Fifth Circuit, does not reflect the substance of the Fifth Circuit's decisicn, and is not the question to be considered for review by this Court.

If review were considered necessary, there would be two questions for analysis. The first would be whether an insurance company's combining and conspiring with retail pharmacy chains to fix prices in the retail pharmaceutical industry constitutes the "business of insurance," where the price fixing agreement is not required by the insurance policy or by the State of Texas and is not considered part of the "business of insurance" by Texas. The second question would be whether retail pharmacy chains can avoid the Sherman Act's proscriptions by combining with an insurance company and utilizing it as an intermediary to eliminate price and other forms of competition in the retail pharmaceutical industry.

Despite Petitioners' assertion, Respondents are not challenging "direct contractual arrangements between an insurer and third parties to provide benefits owed to the insurer's policyholders." The Fifth Circuit expressly recognized that the particular activities challenged by Respondents *are not* "benefits owed to the insurer's policyholders" and *are not* "required by the policy of insurance." *See* App. B, at 15b (556 F. 2d at 1382). Respondents are challenging Petitioners' combination to eliminate price and other forms of competition in the retail pharmaceutical industry.

The Petitioners are asking this Court to grant blanket McCarran-Ferguson Act (McCarran Act) immunity to *all activities* that might be included in direct contractual arrangements between insurers and providers of benefits. The Fifth Circuit followed this Court's ruling in *S.E.C. vs. Nat'l Securities, Inc.*, 393 U.S. 453 (1969), and refused to grant blanket antitrust immunity. It followed the correct legal standard by analyzing each challenged activity to determine whether it was a part of the "business of insurance" and noted that "[anticompetitive practices] do not become clothed with McCarran Act protection simply because an insurance company has contracted to pay the provider for goods or services." App. B, at 23b (556 F. 2d at 1386).

GENERAL

The factual underpinnings of this cause are crucial to a determination concerning the McCarran Act's applicability as is graphically illustrated by Petitioners' first footnote, wherein Petitioners assert that "[t]he operative facts are *essentially uncontested* and are *fully* and *fairly* set forth in the District Court opinion." Petition at 3, n.1 (emphasis added). The patent fallacy of this statement must be underscored and will, in itself, largely explain the Fifth Circuit's reversal of the District Court's summary judgment for Petitioners. As a reading of the Fifth Circuit's opinion demonstrates, the Fifth Circuit rejected the District Court's construction of the facts after a thorough analysis of the record.

Due to the central importance of the facts to the McCarran Act issue, Respondents must discuss them at length and specifically indicate misstatements or overstatements of fact contained in the Petition. It is hoped that any initial displeasure felt by the Court with respect to Respondents'

criticizing Petitioners' factual representations or those of the District Court will be tempered by a very close scrutiny of the facts as found by the Fifth Circuit as compared with the differing factual representations of Petitioners and Respondents.

STATEMENT OF THE CASE

In 1969, Blue Shield began offering prescription drug insurance coverage in Texas. Contemporaneous to its making prescription drug insurance available, Blue Shield began entering into Participating Drug Pharmacy Agreements (The Pharmacy Agreement) with retail pharmacies. Petitioners claim that the "purpose" of The Pharmacy Agreement is merely "to provide benefits to the insureds under the [prescription drug insurance] policies." Petition at 3. The Fifth Circuit correctly rejected this contention and observed that "the Pharmacy Agreement goes beyond Blue Shield's obligations as an insurer." App. B, at 15b (556 F. 2d at 1382).

The Pharmacy Agreement is simply a price fixing agreement. Pursuant to its terms, the participating pharmacy agrees to charge as its retail sales price for all sales of prescription pharmaceuticals to Blue Shield's subscribers an amount equal to the pharmacy's acquisition cost for the particular drug plus a "professional dispensing fee of $2.00". Each of the "Participating Pharmacies" knows that his competitors who sign The Pharmacy Agreement will be charging the same prices and that concerted action with respect to retail sales prices is contemplated and invited.

The pharmacies that sign The Pharmacy Agreement can charge no more for their prescription drugs than the amount specified therein, regardless of the magnitude of a particular drug's acquisition cost. Thus, the participating pharmacy

is limited to a two dollar ($2.00) markup (the "professional dispensing fee") whether its actual acquisition cost for a particular drug is eight dollars ($8.00) or eighty dollars ($80.00). With respect to specialized and highly expensive pharmaceuticals, The Pharmacy Agreement can result in the pharmacy's being allowed a markup that will not even cover the interest on its investment in inventory.

The retail sales price, as fixed in The Pharmacy Agreement between Blue Shield and the Petitioner pharmacy chains, has been set at a level below that at which small independent pharmacies can profitably compete and conduct business. Only large, high volume chains that sell many items in addition to pharmaceuticals can afford to operate pursuant to The Pharmacy Agreement. Additionally, The Pharmacy Agreement fixes the retail sales price for pharmaceuticals at a level that eliminates the small independent pharmacies' one effective means for competing with the large chains — the provision of services. Signatories of The Pharmacy Agreement are limited to the same retail sales price whether they provide home deliveries, twenty-four (24) hour service, or no service at all. The price set by The Pharmacy Agreement is at a level that does not enable the small independent pharmacies to provide extra services. Thus, their ability to compete is effectively destroyed.

The Pharmacy Agreement eliminates price competition and competition in services as well and constitutes a per se violation of Section One of the Sherman Act, 15 U.S.C. § 1 (1970). Each of the Petitioner pharmacy chains has executed one or more Pharmacy Agreements and otherwise combined and conspired with Blue Shield, and with each other, to fix the retail sales prices for prescription pharmaceuticals.

Blue Shield's plan of operation contemplates the fixing of retail sales prices in the retail pharmaceutical industry

generally. The small independent pharmacies are given the choice of either signing the price fixing agreement or being eventually forced from business. In reality, the choice is no choice, since the result of their signing the price fixing agreement is also eventual elimination.

The coercion of the small independent pharmacies to sign the price fixing agreement is brought about by the Petitioners' conspiracy to effect a boycott by Blue Shield's subscribers of the non-signing pharmacies and by their conspiracy to foreclose such pharmacies from a substantial portion of the market. A pharmacy that refuses to sign the price fixing agreement is effectively foreclosed from making further pharmaceutical sales to Blue Shield's subscribers because Blue Shield's subscribers are coerced not to patronize the non-signer.

Coercion of the subscribers is two-pronged. First, the subscriber receives markedly reduced benefits if he patronizes a pharmacy that refuses to sign the price-fixing agreement. While he is required to pay only the two dollar ($2.00) drug deductible for each prescription filled by a "participating pharmacy," he must ultimately pay an amount representing twenty-five (25%) percent of a "reasonable charge" for the drug, as determined by Blue Shield, in addition to the two dollar ($2.00) drug deductible, for each prescription filled by a non-signing pharmacy. Thi[illegible] monetary penalty for patronizing a pharmacy that refuses to sign the price fixing agreement arises because Blue Shield will reimburse the subscriber only seventy-five percent (75%) of a "reasonable charge" for the drug, as determined by Blue Shield, less the two dollar ($2.00) drug deductible, when non-signing pharmacies are patronized. Deposition testimony revealed no studies by Blue Shield that would justify this differential in benefits.

Obviously, the differential in benefits is intended to coerce Blue Shield's policyholders not to patronize non-signing pharmacies in Texas and thereby to coerce such pharmacies to sign the price fixing agreement. This purpose of coercion is graphically illustrated by the fact that under Blue Shield's prescription drug insurance "program", the subscriber will be reimbursed *100% of a "reasonable charge"* for the drug, less the two dollar ($2.00) drug deductible, *when he patronizes a non-signing pharmacy outside the State of Texas.* There could be no reason for distinguishing between non-signing pharmacies inside Texas and those outside the State, other than the fact that coercion of the latter would serve no useful purpose for Blue Shield.

There is a second and much more subtle step to the coercion. If a subscriber patronizes a participating pharmacy, the pharmacy is reimbursed directly by Blue Shield in the amount of its acquisition cost for the drug, and the subscriber is obligated to personally pay the pharmacy at the time of purchase only the two dollar ($2.00) drug deductible (in effect, the "professional dispensing fee"). However, when a pharmacy refuses to sign the price fixing agreement, Blue Shield refuses to deal with the pharmacy directly, and the subscriber must pay the entire retail sales price at the time of purchase rather than merely the two dollar ($2.00) deductible that he pays a Participating Pharmacy. After paying the entire sales price at the time of purchase, he must file a claim with Blue Shield seeking reimbursement (which will equal only seventy-five percent (75%) of a "reasonable charge" for the drug, as determined by Blue Shield, less the two dollar ($2.00) drug deductible).

The pressures exerted on the subscriber are obvious. That these pressures are aimed at coercing the subscribers not

to patronize the non-signing pharmacies, and thereby to coerce such pharmacies to sign the price fixing agreement, cannot be doubted. Whether the subscriber patronizes a signing or non-signing pharmacy, the same claim form is utilized; the same information is necessary to its completion; and the pharmacist's assistance is needed in providing this information. Significantly, the claim form itself directs the insured *to have the non-participating pharmacy* complete the prescription information section. Thus, since the pharmacy must participate in claims administration in both instances, no purpose is served by Blue Shield's refusal to deal directly with non-participating pharmacies other than to coerce them through the harassment of its policyholders. When the policyholder files his own claim, it is more involved for him than if he had patronized a participating pharmacy who would file the claim for him, and he must await reimbursement.

It is a rare subscriber indeed who is willing to accept reduced benefits and to undergo the administrative burden in order to patronize the pharmacy of his choice. Since the Prescription Drug Insurance Policy confers far more benefits on him when he patronizes a Participating Pharmacy than it does when he patronizes one that has refused to sign the price fixing agreement, he is subtly, but actually, coerced to purchase pharmaceuticals solely from Participating Pharmacies. The effectiveness of this coercion cannot be doubted. Of the 31,000 prescription claims per month processed by Blue Shield in late 1975, *only 1.9%* represented prescriptions filled by non-participating pharmacies. Thus, through the above mentioned methods of coercion, the Petitioners have effectively allocated to the signatories of the price fixing agreement virtually all sales of prescription pharmaceuticals to Blue Shield's subscribers. The coercion effectively fore-

closes the non-signing pharmacies from a substantial portion of the market and, therefore, constitutes an unreasonable restraint of trade in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1 (1970).

The Petitioner pharmacy chains play a central role in the conspiracy to set the retail sales price of pharmaceuticals, the conspiracy to effect a boycott of Respondents, and the conspiracy to foreclose Respondents from a substantial portion of the market. It is only through the participation of the petitioner pharmacy chains that the small independent pharmacies can be whipsawed into agreeing to fix their retail sales prices. By combining with the petitioner pharmacy chains, who have many outlets, Blue Shield has guaranteed that its policyholders will not have to choose between geographical convenience and reduced policy benefits when deciding whether to patronize a non-signing pharmacy. The policyholder will generally find one of the petitioner pharmacy chains outlets to be readily accessible. The petitioner chains help guarantee that the sole factors in the policyholder's mind will be the markedly reduced policy benefits and administrative inconvenience that he will have to suffer if he patronizes a non-signing pharmacy.

Petitioners seek to avoid scrutiny of their activities under the Sherman Act by alleging that their conduct is merely the "business of insurance" and falls within the protective umbrella of the McCarran Act, 15 U.S.C. §§ 1011 *et seq.* (1970). They erroneously represent that their "*program* is regulated by the State of Texas," that "*permission* for its use has been obtained from the appropriate authorities", and that the Commissioner of Insurance "authorized" issuance and use of the prescription drug insurance policy form *and* The Pharmacy Agreement in the State of Texas. Petition at 4 (emphasis added).

Petitioners' representation that the Commissioner of Insurance authorized issuance and use of The Pharmacy Agreement is erroneous and has no foundation in fact. As the Fifth Circuit expressly stated, "[i]t is clear from the record that the Board [of Insurance] has never approved The Pharmacy Agreement." App. B, at 19b (556 F. 2d at 1384). The Pharmacy Agreement has never been approved, authorized, or regulated by the Board of Insurance. Nor has the Board ever purported to have authority to authorize or regulate The Pharmacy Agreement or Petitioners' price fixing conspiracy associated therewith. In addition, Texas does not regulate the rates charged for the coverage included here nor the reimbursements to pharmacies from insurers.

In stating that their "program" is regulated by the State of Texas and that permission for its use has been obtained from the appropriate authorities, Petitioners imply that all of their activities, including those challenged by Respondents, have been studied, considered, approved, or regulated by the "appropriate" authorities. In no instance was The Pharmacy Agreement and its attendant price fixing approved, authorized or in any manner treated as a part of the business of insurance in Texas. The Fifth Circuit rejected Petitioners' contentions in this regard after a careful reading of the various opinions, letters, and other documents emanating from the various officials and agencies of the State of Texas.

In their "Statement of the Case", Petitioners allege that Blue Shield has entered into The Pharmacy Agreement with pharmacies throughout the State of Texas "[i]n order to implement the benefits provisions of the policies." Petition at 4-5. As the Fifth Circuit concluded, The Pharmacy Agreement has little to do with "implementing the benefits pro-

visions" of Blue Shield's policies. The fixing of retail sales prices for pharmaceuticals and the coercion of pharmacies to fix their prices *are not* benefits owed to the insureds under the insurance contract. Indeed, Blue Shield's sole obligation is to see that *the insured* receives prescription drugs and "*shall be required to pay no more* than the drug deductible for each of such covered drugs." The conspiracy to fix prices is merely a profit-maximizing endeavor for Blue Shield's benefit.

Blue Shield is no more obligated to its policyholders to fix the retail sales prices of pharmaceuticals than an automobile insurer is obligated to its insureds having $100 deductible policies to fix the prices to be charged in the future by body shops for parts and labor. To call this activity the "implementation of policy benefits" is a veritable *tour de force.*

Petitioners have erroneously attributed to Respondents the following contention:

> [T]hat in contracting with pharmacies to provide the policy benefits to its insureds, Blue Shield is somehow not engaged in the "business of insurance" within the meaning of the McCarran Act. Petition at 5.

In no respect are Respondents making the contention attributed to them. The Pharmacy Agreements do much more than merely require the Participating Pharmacies to dispense covered pharmaceuticals to Blue Shield's insureds.

The Pharmacy Agreements serve as a vehicle by which competing pharmacies conspire and agree concerning the *total price* that *they will charge* for dispensing pharmaceuticals to Blue Shield's policyholders. By virtue of The Pharmacy Agreements' price fixing provision, Blue Shield and

the petitioner pharmacy chains are conspiring to eliminate price and other forms of competition in the retail pharmaceutical industry. It is these activities that Respondents contend do not constitute a part of the "business of insurance." As the Fifth Circuit noted:

> [I]t is not the office of the insurance industry to set the prices in the various sectors of our economy so that insurers will enjoy an added measure of control over the magnitude of individual claims. App. B, at 18b (556 F. 2d at 1384).

Throughout their Petition, Petitioners ignore the activities embraced by The Pharmacy Agreement. They discuss the Agreement in the abstract as an innocuous "direct contractual relationship between an insurer and the providers of benefits for the provision of policy benefits owed to the insureds."

On page 6 of their Petition, Petitioners make the following statement:

> Despite the District Court's findings that The Pharmacy Agreement is inextricably linked to and in fact required by the policy provisions relating to benefits and coverage, the Court of Appeals concluded that "Blue Shield's policyholders are basically unconcerned with the contract between the insurer and the Participating Pharmacy."

Petitioners conveniently take the Fifth Circuits' quoted language out of context and omit the important sentence that precedes it.

> It is unnecessary for Blue Shield to agree with pharmacies to fix retail sales prices in the pharmaceutical industry. App. B, at 12b (556 F. 2d at 1381).

Petitioners fail to point out that the Fifth Circuit *expressly rejected* the District Court's finding that The Pharmacy

Agreement "is inextricably linked to and in fact required by the policy provisions relating to benefits and coverage." The Fifth Circuit analyzed the particular activities embraced by the Agreement. It was this analysis which led the appellate court to conclude that "Blue Shield's policyholders are basically unconcerned with the contract".

The Fifth Circuit stripped The Pharmacy Agreement of its self-serving language concerning the provision of benefits and recognized it is nothing more than a price fixing agreement. It refused to pervert the McCarran Act's language beyond all reason and hold that the Petitioners' challenged activities constitute the "business of insurance." The Fifth Circuit correctly held as follows:

> [T]here is no . . . indication that the activities complained of are considered the business of insurance by the State *or by any common sense interpretation of that term.* App. B, at 21b (556 F. 2d at 1385) (emphasis added).

RESPONSE TO REASONS FOR GRANTING THE WRIT

I. The Fifth Circuit's Decision Does Not Conflict With The Decision of Any Other Court of Appeals.

Petitioners try to create a conflict between the Fifth Circuit's decision and the decisions of other courts of appeal with the following contention:

> The decision below stands alone and is in direct conflict with every other court of appeals decision which has had occasion to consider whether the "business of insurance" includes an insurer's dealings with third parties to *satisfy obligations due to its insureds.* Petition at 7 (emphasis added).

Although Petitioners endeavored to convince the Fifth Circuit that such issue was at the heart of the present controversy, the appellate court correctly recognized that the particular activities challenged by Respondents *are not* "dealings with third parties to satisfy obligations due . . . [Blue Shield's] insureds." Indeed, the essence of the Fifth Circuit's opinion is the following:

> We find that The Pharmacy Agreement goes beyond Blue Shield's obligations as an insurer and places the firm in the business of providing goods and services. Blue Shield has agreed to provide protection against the risk that a policyholder will require pharmaceuticals. In order to meet that obligation, Blue Shield is not required to guarantee the provision of services on a "cost plus" basis or any other basis which might be more economical than the retail purchase of such products. App. B, at 15b (556 F. 2d at 1382).

The Fifth Circuit's decision does not conflict with the decision of any other court of appeals. Neither the Third, the Fourth, nor the D. C. Circuits have held that "participating agreements" between insurers and providers of benefits are automatically and in all cases part of the "business of insurance." None of these courts held that any and all activities embraced by such "participating agreements" are part of the "business of insurance." Each of the decisions by these courts has turned on the specific facts of the case and on the specific activities being challenged. A close reading of the cases discloses facts and activities unlike those in this case.

The trilogy of cases decided by the Third Circuit began with *Travelers Ins. Co. v. Blue Cross of Western Pennsylvania*, 481 F. 2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093

(1973). The Fifth Circuit recognized that *Travelers* carries little precedential value in this appeal." App. B, at 176 (556 F. 2d at 1383). *Travelers* and its progeny, *Doctors, Inc. v. Blue Cross of Greater Philadelphia*, 1977-1 Trade Cas. ¶ 61,420, at 71,560 (3d Cir. 1977), *aff'g per curiam*, Civil Action No. 73-1057 (E.D. Pa. Aug. 13, 1975), and *Frankford Hospital v. Blue Cross of Greater Philadelphia*, 554 F. 2d 1253 (3d Cir.), *cert. denied*, ... U.S. ....., No. 77-171 (Oct. 3, 1977), involve a very special fact situation wholly unlike that in this case. These cases cannot be cited for the proposition that direct contractual relationships between insurers and the providers of benefits, which relate in some manner to the provisions of benefits, necessarily constitute the business of insurance with respect to all activities embraced by the agreements.

While *Travelers* involved a direct contractual relationship between an insurer and the providers of benefits, the similarity between that case and the present one ends with this single characteristic. The fact that there was a direct contractual relationship between Blue Cross and the providers of benefits, some non-profit hospitals, did not in itself serve as the basis for the Third Circuit's opinion. Only after one reads the District Court's opinion in *Travelers*, and thereby gains an understanding of the highly specialized facts in that case, can the true basis of the Third Circuit's opinion be understood. See, *Travelers Ins. Co. vs. Blue Cross*, 361 F. Supp. 774 (W.D. Pa. 1972), *aff'd*, 481 F. 2d 80 (3d Cir.), *cert. den.*, 414 U.S. 1093 (1973).

In *Doctors, Inc. v. Blue Cross*, Civil Action No. 73-1057 (E.D. Pa. Aug. 13, 1975), *aff'd per curiam*, 1977-1 Trade Cas. ¶61,420, at 71,560 (3d Cir. 1977), the Court correctly observed that the decision in *Travelers* was based on the specialized provisions of Pennsylvania law — provisions having no counterpart in Texas and that are totally alien to the facts of the present case. The Court in *Doctors, Inc.* correctly construed the narrowness of the Third Circuit's holding in *Travelers* as follows:

> It is therefore readily apparent from the reading of the *Travelers* case that *the Third Circuit is approving the actions of the Insurance Commissioner of Pennsylvania* when he exerts pressure on the large insurance companies to get them to exercise their power over hospitals to force the hospitals to cut costs wherever possible. *Id.* at 9 [emphasis added].

The fact that there was a direct contractual relationship between Blue Cross and the non-profit hospitals was not in itself important.

Of crucial importance to the *Travelers* opinion was the fact that Pennsylvania's legislature had chosen to control the rates charged by non-profit hospitals through a *statutorily* created interrelationship between the rates charged by non-profit health insurers and non-profit hospitals, which interrelationship was to be regulated by the Pennsylvania Insurance Department. As the District Court observed in *Travelers*:

> [T]he activities of Blue Cross in all respects material to this case, *including the terms of the contract under attack*, are regulated and *directed* by the Insurance Department of the Commonwealth of Pennsylvania in strict conformity with the provisions of the Nonprofit Hospital Plan Act of 1973 . . . . *Travelers Ins. Co. vs. Blue Cross*, 361 F. Supp. 774, 776 (W.D. Pa. 1972) [emphasis added].

Additionally, it observed the following with respect to Pennsylvania's Nonprofit Hospital Plan Act:

> "Under the terms of said act, Blue Cross having been previously organized under the Pennsylvania Nonprofit

> Corporation Law . . . for the purpose of establishing, maintaining and operating such a *non-profit hospital plan* became the subject of regulation by the Pennsylvania Insurance Department in the following respects:
>
> > 'the rates charged to subscribers . . ., *all rates of payments to hospitals . . ., and any and all contracts entered into . . . with any hospital.*' . . . *The Blue Cross Hospital contract is, therefore, an integral part of Pennsylvania's regulated hospital plan.*" *Id.* at 777 [emphasis added].

It can be seen, then, that the Pennsylvania legislature had chosen to indirectly control the rates charged by non-profit hospitals by charging the Insurance Department with the task of directing and controlling the terms of contracts between *non-profit* health insurers and *non-profit* hospitals and with controlling the rates of payments by non-profit insurers to non-profit hospitals.

The role of the Pennsylvania Insurance Department in determining the terms of Blue Cross' contracts with non-profit hospitals is very extensive as is shown in *Frankford Hospital vs. Blue Cross*, Civil Action No. 74-2281 (E.D. Pa. June 8, 1976), *aff'd per curiam*, 554 F. 2d 1253 (3rd Cir.), *cert. denied*, ... U.S. ....., No. 77-171 (Oct. 3, 1977). *Frankford* involved a challenge by a non-profit hospital to Blue Cross' contract with hospitals. The District Court relied on the *Travelers* opinion and stressed as follows:

> "Both the rates Blue Cross charges to subscribers and its rate of payments to hospitals must be approved in advance by the Insurance Department before they can go into effect. 40 Pa. C.S.A. § 6124. . . . The Department instructed Blue Cross to develop a uniform contract [with non-profit hospitals]. It particularly stressed that this contract should include the cost accounting principles upon which reimbursement under the federal Medicare Program was based." *Id.* at 3.

The Court noted that when Blue Cross first submitted its proposed uniform cost contract between itself and Philadelphia area hospitals, the contract was rejected by the Insurance Commissioner, who instructed Blue Cross that it was not to pay for any portion of the hospitals' unreimbursed outpatient cost or for costs of depreciation. The Commissioner viewed these costs as a "community responsibility, including federal, state and local governments as well as eleemosynary institutions . . ." *Id.* at 3-4.

Finally, the Hospital Agreement of 1971 was approved, "the terms of which reflected Commissioner Denenberg's negotiating guidelines." *Id.* at 5. When the 1971 Agreement expired in 1974, a number of hospitals refused to sign a new hospital agreement with Blue Cross, in response to which "the Commonwealth of Pennsylvania enacted Act No. 94 of 1975, (40 P.S. § 6124c). It reinstated, retroactively, the 1971 Hospital Agreement between Blue Cross and the non-member DVHC hospitals." *Id.* at 6. Considering this factual background, it is evident that the *Travelers* opinion in no sense conflicts with the Fifth Circuit's decision in the present controversy and certainly cannot be cited for the broad proposition that "participating agreements" between an insurer and a provider of benefits are *ipso facto* shielded by the McCarran Act from antitrust challenge. The mere fact that a conspiracy to fix prices is embodied in a "participating agreement" does not invoke McCarran Act immunity.

The Fifth Circuit expressly recognized that the Third Circuit's decisions were not in conflict with its holding. Petitioners have misconstrued the Fifth Circuit's reading of the Third Circuit's opinions and, in the process, have erroneously attributed to the Fifth Circuit the reasoning that

"unless there is state regulation, a company cannot be engaged in the "business of insurance." Petition at 10.

The Fifth Circuit did not employ the reasoning Petitioners attribute to it. Rather, its discussion concerning the role played by Pennsylvania's Insurance Commissioner and legislature in the execution of Blue Cross' "participating agreements" was intended to demonstrate that there was no conspiracy between Blue Cross and the participating hospitals to fix prices. In executing the agreements and in drafting their contents, Blue Cross was merely performing obligations that it owed to its insureds *by virtue of the unique features of Pennsylvania law*. Blue Cross was doing what Pennsylvania law *required* it to do in order to underwrite insurance *covering health care at non-profit hospitals*. The Third Circuit was not confronted with a conspiracy to fix prices in a private sector of the economy. Rather, it was confronted with an agreement that was the product of unique features of Pennsylvania law — an agreement that was ultimately enacted into law by the Pennsylvania legislature.

The Fifth Circuit contrasted the present controversy with the Third Circuit's cases by emphasizing that Blue Shield, in conspiring to fix the retail sales prices for pharmaceuticals, is not performing obligations that it owes its insureds under the insurance policy or under any aspect of Texas law. It recognized that Blue Shield is attempting to subvert free market competition in a private, non-insurance sector of our economy. Such activity is not the "business of insurance."

Another of the "conflicting" decisions cited by Petitioners is *Proctor v. State Farm Mut. Auto Ins. Co.*, 561 F. 2d 262 (D.C. Cir. 1977), *petition for cert. pending*, No. 77-580. *Proctor* cannot be cited for the proposition that all direct contractual arrangements between insurers and providers of

benefits are automatically a part of the "business of insurance." Rather, the D. C. Circuit emphasized that "[t]he question [whether an activity is part of the 'business of insurance'] is ultimately one of line-drawing, based on the facts of the individual case." *Id.* at 268. The D. C. Circuit cited the District Court's opinion in this case with approval, but did so prior to the Fifth Circuit's correcting the erroneous statements of fact on which the District Court's legal conclusions were premised. If it had been given the benefit of the facts as they actually exist, the D. C. Circuit most assuredly would not have cited the District Court's opinion with approval.

Proctor involves a challenge to a "horizontal agreement [among insurers] to pay or reimburse *their policyholders* according to a common formula." *Id.* at 264 (emphasis added). In essence, the case involves a challenge to insurers' conspiring among themselves concerning the maximum dollar amount of coverage the insurers will provide per claim for their insureds. The present cause, by contract, involves a challenge to a conspiracy between an insurer and retail pharmacy chains concerning the *retail prices to be charged by the retail pharmaceutical industry* for its goods and services. There is no indication that the D. C. Circuit would consider the latter activity to constitute the business of insurance.

Petitioners' reliance on *Anderson v. Medical Service of the District of Columbia*, 551 F. 2d 304 (4th Cir. 1977), *aff'g per curiam*, 5 Trade Reg. Rep. ¶60,884, at 68,855 (E.D. Va. 1976), to create a conflict with the Fifth Circuit's decision is also misplaced. Although *Anderson* did involve direct contractual relationships between an insurer and the providers of benefits, physicians, the opinion was not based on the

mere fact that the challenged activity was embodied in a direct contract between an insurer and the providers of benefits. The district court in *Anderson* stressed the fact that the challenged activity did not operate to fix prices. The court further stressed that the insureds were not coerced to patronize participating physicians and that policy benefits were the same whether the subscriber patronized a participating or non-participating physician. 5 Trade Reg. Rep. ¶60,884, at 68,857. The fact situation in *Anderson* differs markedly from that in this case where prices are fixed and Blue Shield's subscribers must pay a sizeable financial penalty in the form of markedly reduced policy benefits if they patronize non-participating pharmacies.

The absence of a conflict between the Fifth Circuit's opinion and those of the other courts of appeals perhaps is most graphically illustrated by Petitioners' own observation concerning the other courts' decisions —

> [T]he Courts of Appeals for the District of Columbia, Third and Fourth Circuits all have held that the satisfaction of obligations due the insured . . . is at the "core of the 'business of insurance'. . . . [Petition at 10].

The Fifth Circuit focused on the activities in question. It held that the particular activities challenged by Respondents are *not* obligations due the insureds and that Blue Shield is not obligated to fix the retail sales prices in the pharmaceutical industry. App. B, at 12b-15b (556 F. 2d at 1381-82).

Petitioners erroneously claim a conflict between the Fifth Circuit's opinion and opinions by the Third and Seventh Circuit's with respect to the Fifth Circuit's holding that the

petitioner pharmacy chains are not engaged in the business of insurance. *See* Petition at 10. Contrary to the impression Petitioners try to create, the Fifth Circuit did not hold that non-insurance company defendants can never qualify for McCarran Act protection. Rather, it held that the petitioner pharmacy chains, in selling pharmaceuticals and in conspiring to fix the retail sales prices of pharmaceuticals, are not engaged in the "business of insurance." Neither of these activities are activities classically performed by insurance companies.

Although the Seventh Circuit in *Lowe v. Aarco-American, Inc.*, 536 F. 2d 1160 (7th Cir. 1976), did cloak two non-insurance company defendants with McCarran Act immunity concerning alleged violations of the Truth in Lending Act, the holding of that case is much narrower than Petitioners imply. The defendants were an insurance broker and a premium finance company. They were sued for alleged violations of the Truth in Lending Act that allegedly occurred in their credit sales of insurance policies. The Seventh Circuit correctly held that the credit sales of insurance policies are part of the business of insurance and correctly invoked McCarran Act immunity. Although the two defendants in *Lowe* were not insurance companies, they were performing activities customarily performed by insurers. One defendant sold automobile insurance policies and the other defendant financed the premiums required under those policies. In this regard, they could be viewed as extensions of the insurance company. The Seventh Circuit expressly noted that Illinois regulates premium finance companies under the Illinois Insurance Code.

The Petitioner pharmacy chains herein, unlike the defendants in *Lowe*, are not performing activities customarily per-

formed by insurers. The fixing of prices in the pharmaceutical industry is not a customary activity of insurance companies, and the Petitioner pharmacy chains cannot by virtue of their price fixing activities be considered extensions of an insurance company. The Texas State Board of Insurance has no authority over pharmacies. Had the Petitioner pharmacy chains engaged in price fixing activities without Blue Shield's participation, there would be little question that a per se violation of the federal antitrust laws was committed. *See United States v. Utah Pharmaceutical Association*, 201 F. Supp. (D. Utah), *aff'd*, 371 U.S. 24 (1962). *Lowe* serves as no precedent for the extension of the McCarran Act to the activities of the Defendant pharmacy chains in conspiring and agreeing to fix prices.

Petitioners have misread the Third Circuit's holding in *Doctors, Inc. v. Blue Cross of Greater Philadelphia*, 1977-1 Trade Cas. ¶61,420, at 71,560 (3rd Cir. 1977). *aff'g per curiam*, Civil Action No. 73-1057 (E.D. Pa. 1975). Petitioners have alleged the following:

> In *Doctors, Inc., supra*, the Court of Appeals for the Third Circuit affirmed the District Court's dismissal of the complaint as to Blue Cross and a private non-participating health care and hospital advisory agency *found to be within the "business of insurance."* Petition at 10. (emphasis added).

Neither the trial nor the appellate court in *Doctors, Inc.* found the advisory agency to be within the "business of insurance". Indeed, not even the advisory agency itself claimed to be engaged in the "business of insurance".

The district court expressly noted that the advisory agency "has filed a motion for summary judgment *on the grounds that it was not a co-conspirator.*" Civil Action No. 73-1057 at 2 (emphasis added). In granting a summary

judgment for the advisory agency, the district court premised its action on the lack of a conspiracy, not on the advisory agency's being within the "business of insurance." In affirming the district court's opinion, the Third Circuit merely held that "the 'business of insurance' provisions of the McCarran-Ferguson Act remove *Blue Cross' conduct* here from coverage of the Sherman Act." 1977-1 Trade Cas. ¶ 6140, at 71,561 (emphasis added). *Doctor's, Inc.* in no sense holds that non-insurance company entities not engaged in activities classically performed by insurance companies can be engaged in the "business of insurance" for McCarran Act purposes.

II. The Fifth Circuit's Decision Does Not Jeopardize The Existence of Prepaid Health Insurance Plans and Will Not Preempt State Regulation of Health Insurance.

A. The Existence of Prepaid Health Insurance Plans

Petitioners pose the following sympathy evoking argument as a basis for this Court's granting a writ of certiorari:

> "By subjecting insurers' contracts with providers of health care services to the antitrust laws, even though such contracts are an inseparable feature of prepaid health insurance policies which are regulated by the states, the decision below threatens the viability of a new and growing segment of the health insurance industry." Petition at 11.

This argument is utterly fallacious and misleading.

The Fifth Circuit *did not* hold that all "insurers' contracts with providers of health care services" are *ipso facto* subject to the antitrust laws or that all activities embraced by such contracts are subject to antitrust scrutiny. Rather, the Fifth Circuit has held that *the particular activities challenged by Respondents* are subject to antitrust scrutiny

despite the fact that Petitioners have camouflaged such activities within contracts between Blue Shield and the Petitioner pharmacy chains.

Petitioners want this Court to expand application of the McCarran Act by granting blanket antitrust exemptions for any and all activities embraced by a contract between a health insurer and providers of benefits. Petitioners' "direct contract" argument is contrary to the McCarran Act. It would make antitrust immunity dependent on contractual arrangements entered into between an insurer and non-insurance parties, not on satisfaction of the McCarran Act requirements. It would mean that any direct contract with an insurer *ipso facto* would exempt all of the contracting parties from the federal antitrust laws, irrespective of whether the parties are engaged in the "business of insurance", as the McCarran Act requires. It thus creates an antitrust exemption not conferred by Congress. While this argument has the virtue of simplicity, it is patently invalid and finds no support in the McCarran Act. Activities do not become a part of the "business of insurance" merely because they are contemplated or embraced by a contract to which an insurer is a party.

A second fallacy of Petitioners' argument is its premise that the activities challenged by Respondents are "an inseparable feature of prepaid health policies which are regulated by the states." The Fifth Circuit correctly found that the price fixing and coercion practiced by Petitioners are *not* an inseparable feature of Blue Shield's health insurance policies, are not peculiar to the "business of insurance," and are not regulated by Texas as a part of the "business of insurance."

The setting of retail prices in the various private sectors of our economy certainly is not encompassed by the business

of insurance. As the Fifth Circuit correctly recognized, an insurer "is not required to guarantee the provision of services on a 'cost-plus' basis or any other basis which might be more economical than the retail purchase of such products." App. B, at 156 (556 F. 2d at 1382).

Congress did not contemplate that the McCarran Act be utilized to insulate all activities by insurers from the federal antitrust laws. As one Court recently observed,

> "The role of insurance in our complex commercial society is pervasive. Insurance companies with their policies, their agents and their customers touch and concern all commercial activity. The McCarran-Ferguson Act did not purport to make state legislation supreme in regulating all the activities of insurance *companies*. It does allow the states to regulate the *business* of insurance . . . but such business is not the subject of this litigation." *Devoto vs. Pacific Fidelity Life Ins. Co.*, 354 F. Supp. 874 (N.D. Calif. 1973) [emphasis in original], *aff'd as to holding on McCarran Act, rev'd and remanded on other grounds*, 516 F. 2d 1, 3 (9th Cir. 1975).

Such business likewise is not the subject of the present litigation!

Petitioners innocuously describes their price fixing conspiracy as "*negotiating* in advance the price of health care services furnished by the provider." Petition at 12 [emphasis added]. They attempt to justify such activity on the thesis that price fixing in the provider industry enables the insurer to offer reduced rates because the insurer will know in advance the cost of the benefits it will have to provide. *Id.* They also argue that they magnanimously are trying to stop the "rapid escalation in the cost of health care serv-

ices." Petition at 12. The Fifth Circuit correctly rejected these arguments with the following observation:

> That Blue Shield may wish to protect itself and its customers from rising costs in the pharmaceutical industry does not transform The Pharmacy Agreement into the business of insurance. App. B, at 15b (556 F. 2d at 1382).

A price fixing conspiracy is not automatically a part of the business of insurance merely because an insurer is a party to the conspiracy.

Although public spirited motives invariably are professed by price fixers, the fact remains that price fixing is illegal per se. "It makes no difference whether the motives of the participants are good or evil; . . . or whether the effect of the agreement is to raise or lower prices." *United States vs. McKesson & Robbins, Inc.*, 351 U.S. 305, 310 (1956). Nor can desirable business consequences justify price-fixing arrangements. *United States vs. Masonite Corp.*, 316 U.S. 265, 276 (1942). Congress has dictated that prices in the various private sectors of our economy are to be determined by free market forces, not by conspiracies among entities with market power.

Despite the laudable motives articulated by Petitioners in their Petition, Blue Shield merely is attempting to increase its profits at the expense of competition in the retail pharmaceutical industry, and the Petitioner pharmacy chains are attempting to eliminate small independent pharmacies as competitors. These activities do not constitute the "business of insurance."

If an insurer desires to minimize its risks by controlling the maximum dollar amount of each claim, it can specify in the insurance policy the maximum benefits available per

claim. Such activity does not infringe on competition and free market forces in private, non-insurance sectors of our economy.

Blue Shield has endeavored to stretch and distort the McCarran Act beyond Congress' wildest expectations. Congress never intended, and the Fifth Circuit refused to allow, the McCarran Act to be perverted in the manner sought by Blue Shield.

B. State Regulation of Health Insurance

Petitioners assert that the Fifth Circuit's decision "infringes upon the *extensive* state regulation of health care plans." Petition at 13 [emphasis added]. Were it not for the importance of the hallowed forum in which this ridiculous contention is being made, Petitioners' assertion would be ludicrous. In their protestations concerning "extensive state regulation of health care plans," Petitioners curiously avoid citation *of a single Texas statute* that is in any respect impaired, invalidated, or superseded by the Fifth Circuit's opinion.

In essence, Petitioners argue that state insurance commissioners and not the federal courts should decide what activities constitute the "business of insurance" for McCarran Act purposes. In this respect, Petitioners assert the following:

> This new and fundamental question of the manner in which insurers are to provide benefits to insureds at reasonable rates is precisely the type of question that the insurance commissioners of each state are most competent to examine through such administrative procedures as approval of rates and policy provisions. Petition at 14.

The question what constitutes the "business of insurance" is a federal question, not a question left to state insur-

ance commissioners. *See, S.E.C. v. Nat'l Securities, Inc.*, 393 U.S. 453 (1969); *S.E.C. v. Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1959). Petitioners would have this Court retract its following construction of the McCarran Act:

> "The statute did not purport to make the States supreme in regulating all of the activities of insurance *companies;* its language refers not to the persons or companies who are subject to state regulation, but to laws "regulating the *business* of insurance." Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the "business of insurance" does the statute apply." *S.E.C. v. Nat'l Securities, Inc.*, 393 U.S. 453, 459-60 (1969) [emphasis in original].

Petitioners desire that this Court leave exclusively to the States regulation of any anticompetitive activity formulated by the ingenuity of insurers as long as an insurance company is a party to the activity. The McCarran Act does not grant such a blanket antitrust exemption, and the necessity for presrving a free marketplace in our society requires rejection of this wholesale abandonment of the federal antitrust laws.

Petitioners' argument that the Fifth Circuit's opinion "limits the insurer's function to paying bills and deprives insurers of the ability to *negotiate* the costs of benefits in order to reduce rates and increase coverage," is utterly fallacious. *See* Petition at 14 (emphasis added). The Fifth Circuit held that the McCarran Act will not shield from antitrust scrutiny insurers' conspiracies to fix prices, eliminate competition, and otherwise destroy free market forces in private, non-insurance sectors of our economy. Congress never intended that the McCarran Act be utilized to make private, non-insurance sectors of our economy sacrificial lambs for the benefit of the insurance industry.

CONCLUSION

Petitioners are in essence asking this Court to grant a writ of certiorari in order that this Court may decide a disagreement between the District Court and the Fifth Circuit concerning the operative facts of this case. The Fifth Circuit correctly rejected the District Court's erroneous construction of facts.

Petitioners have uncritically cited several cases for the blanket proposition that any and all activities embraced by health insurance plans and "provider agreements" are automatically a part of the "business of insurance." From such uncritical citation of cases involving facts and activities wholly alien to those before the Fifth Circuit, Petitioners try to create a conflict between the Fifth Circuit's decision and those by other courts of appeal. No such conflict exists.

The Fifth Circuit correctly rejected Petitioners' tortured and expansive reading of the McCarran Act. In so doing, it followed this Court's recent admonition that the various statutory exceptions to the antitrust laws are to be strictly construed. *See, Abbott Labs. v. Portland Retail Druggists Assn.*, ... U.S. ....., 96 S. Ct. 1305, 1313 (1976).

A central purpose of the antitrust laws is the promotion and preservation of marketplaces in which consumers are provided choices or options in terms of the prices, quality and services associated with the products they purchase. To that end, and for the reasons set forth above, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, Joel H. Pullen, do hereby certify that a true and correct copy of the foregoing Respondents' Brief In Opposition To Petition For Writ of Certiorari was served on the Petitioners by mailing three copies thereof to each of their attorneys of record:

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APPENDIX A

Opinion of United States District Court for the Western District of Texas, June 23, 1976

ROYAL DRUG COMPANY d/b/a Royal Pharmacy of Castle Hills and Disco Prescription Pharmacy et al.

v.

GROUP LIFE AND HEALTH INSURANCE COMPANY a/k/a Blue Shield and/or Blue Cross-Blue Shield of Texas, et al.

Civ. A. No. SA-75-CA-131.

UNITED STATES DISTRICT COURT,
W. D. TEXAS
SAN ANTONIO DIVISION

June 23, 1976.

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Memorandum Opinion

JOHN H. WOOD, JR., *District Judge.*

I.

Plaintiffs in this private civil antitrust action are eighteen independent pharmacy owners doing business in San Antonio, Texas. Defendant Group Life and Health Insur-

ance Company, also known as Blue Shield of Texas ("Blue Shield"), is an insurance company duly authorized by the Texas State Board of Insurance to transact the business of life, health and accident insurance within the State of Texas. The remaining three Defendants, Walgreen Texas Co. ("Walgreen"), The Sommers Drug Stores Company ("Sommers"), and Rieger/Medi-Save Pharmacies, Inc. ("Rieger") operate pharmacies in San Antonio, Texas.

Plaintiffs' suit is an attack upon Blue Shield's plan of operation under certain prescription drug insurance policies (the "Policy") which it issues. It is alleged that Defendants have violated Section 1 of the Sherman Act, 15 U.S.C. § 1, by agreeing, combining and conspiring to fix the retail price of drugs and pharmaceuticals, and that the activities of Defendants have caused Blue Shield's insureds not to deal with certain of the Plaintiffs, thereby constituting a group boycott. Plaintiffs further allege that Defendants have violated the Texas antitrust laws, Tex. Bus. & Comm.Code Ann. § 15.01, *et seq.*, and that this Court should exercise pendent jurisdiction over those claims.

Each of the Defendants has separately moved to dismiss the Complaint for lack of jurisdiction over the subject matter and for failure to state a claim upon which relief can be granted. Defendants' motions are based upon the provisions of the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.* The motions also urge that in the absence of any valid cause of action based upon federal law, this Court should dismiss Plaintiffs' pendent claims.

Extensive discovery has been completed on the issue presently before the Court. The record includes numerous depositions, affidavits and documents, and all parties have had full opportunity to present all materials pertinent to Defendants' motions. The Court has carefully reviewed and considered all of those materials, together with the briefs submitted by the parties and the oral argument of counsel.

The facts relevant to Defendants' motions are undisputed. The Policies provide prescription drug insurance coverage. The benefits provided under the Policies entitle Blue Shield's insureds to receive prescription drugs from any pharmacy (a "Participating Pharmacy") that has entered into a written contract (the "Pharmacy Agreement") with Blue Shield. The Policies further provide that the insured is required to pay no more for each prescription filled by a Participating Pharmacy than the amount of the drug deductible set forth in the Policy. The drug deductible is $2.00. Pursuant to the terms of the Pharmacy Agreement, a Participating Pharmacy agrees to dispense drugs to Blue Shield's insureds and to accept $2.00 as full payment from the insured for each dispensed drug. Further, Blue Shield agrees to reimburse the Participating Pharmacy for the acquisition cost of each drug dispensed to its insureds. Under the terms of the Policy, if the insured has his prescriptions filled by a pharmacy other than a Participating Pharmacy, he must pay the full price charged by the pharmacy and then apply to Blue Shield for reimbursement. Blue Shield will then reimburse the insured for 75% of the usual and customary charge for the drug, less the $2.00 deductible.

Walgreen, Sommers and Rieger each own Participating Pharmacies. Blue Shield is not engaged in selling or dispensing prescription drugs as a manufacturer, wholesaler or retailer, but is engaged solely in transacting the business of life, health and accident insurance.

In 1969, Blue Shield sought authority from the Texas State Board of Insurance to begin issuing prescription drug insurance coverage in the form described above. Article 3.42 of the Texas Insurance Code provides that all new policy forms proposed to be issued by life, health and accident insurance companies must be filed with the State Board of Insurance and approved prior to issuance or use by the company. In March, 1969, Blue Shield filed with the

State Board of Insurance a proposed form of the Policy and the Pharmacy Agreement for approval prior to their issuance or use. The terms of the policy provided that Blue Shield's insureds were entitled to receive prescription drugs from Participating Pharmacies (called "participating providers" in the Policy). The Policy defined the term "participating provider" as a pharmacy who "has entered into a written contract [with Blue Shield] for the rendition of covered drugs for which benefits are provided by this [policy]." The Pharmacy Agreement was in the form described above.

In June, 1969, the Commissioner of Insurance issued a written order disapproving the issuance or use of the Policy. The Commissioner also notified the Texas Attorney General in writing of the action taken by the State Board and provided the Attorney General with copies of all pertinent documents. As a result of the disapproval order, Blue Shield did not issue or use the Policy or the Pharmacy Agreement.

Subsequent to the issuance of the disapproval order, the Policy and the Pharmacy Agreement remained under consideration by the State Board of Insurance. In September, 1969, pursuant to Article 3.42(e) of the Texas Insurance Code,* the Commissioner of Insurance issued another written order exempting the Policy from the approval requirements of Tex.Ins.Code Ann. art. 3.42.

The exemption order issued by the Commissioner of Insurance provided, in pertinent part:

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*"The Board of Insurance Commissioners may, by written order, exempt from the requirements of this Article for so long as it deems proper, any insurance document or form specified in such order to which in its opinion this Article may not practicably be applied, or the filing and approval of which are, in its opinion, not desirable or necessary for the protection of the public." Tex. Ins.Code Ann. art. 3.42(e).

"Pursuant to the authority granted by Article 3.42, Paragraph (e) of the Texas Insurance Code, the Commissioner of Insurance hereby exempts from the requirements of said Article Policy Form CC-OHDS-2 submitted by Group Life and Health Insurance Company, Dallas, Texas; and this exemption shall remain effective pending further orders from the Commissioner of Insurance.

"The exempt forms are described as drug service contracts, which confer upon the policy holder the right to obtain certain prescribed drugs at a cost fixed in the contract, the insurer having entered into participating agreements with dispensing pharmacies to supply the prescribed drugs to its policy holders."

It is clear that the exemption order exempted the Policy from nothing more than the requirement of approval by the State Board of Insurance. The former Deputy Commissioner of Insurance, who reviewed the Policy and the Pharmacy Agreement and then prepared the exemption order for the Commissioner's signature, testified on oral deposition that exempted policies are subject to all statutory requirements of the Texas Insurance Code and all regulatory requirements of the State Board of Insurance. He further testified that exempted policies and approved policies are subject to the same continuing regulation, control and supervision by the State Board. Other officials of the State Board of Insurance testified on oral deposition that exempted policies and approved policies are treated alike within the regulatory framework of the State Board of Insurance.

Further, the exemption order clearly shows that the Commissioner of Insurance considered the Pharmacy Agreement together with the Policy prior to issuing the exemption order. The exemption order authorized Blue Shield to issue and use the Policy in the State of Texas in

the same manner as if it had been approved. Subsequent to the issuance of the exemption order, the Commissioner again advised the Texas Attorney General in writing of his action and forwarded a copy of the exemption order to the Attorney General. The exemption order has not been modified or rescinded.

Thereafter, Blue Shield made a statewide mailing to licensed pharmacies offering them the option of entering into the Pharmacy Agreement. Subsequent to the issuance of the exemption order, Blue Shield has issued the policy to various groups and entered into the Pharmacy Agreement with pharmacies throughout the State of Texas.

In 1974, Blue Shield entered into a health care agreement to provide insurance benefits to groups in Bexar County, Texas. Included in the proposed coverage was prescription drug insurance. In September, 1974, pursuant to Tex.Ins.Code Ann. art. 3.42, a Policy form virtually identical to the one submitted in 1969 was filed with the State Board of Insurance for approval prior to issuance or use in connection with the Bexar County program. Thereafter, in October, 1974, the Commissioner of Insurance issued a written order approving the Policy for issuance. Since receipt of the approval order, Blue Shield has issued the Policy to various groups in Bexar County, Texas. Blue Shield offered to virtually all licensed pharmacies in San Antonio, Texas, the opportunity of entering into a Pharmacy Agreement. Nine of the Plaintiffs accepted Blue Shield's offer and now operate Participating Pharmacies.

Plaintiffs agree that Blue Shield is engaged in the business of issuing prescription drug insurance coverage; however, they contend that the McCarran-Ferguson exemption is inapplicable in that Blue Shield has exceeded the business of insurance by entering into the Pharmacy Agreements, and that such agreements have nothing to do with the business of insurance. Plaintiffs further contend that regardless of whether or not Blue Shield is engaged in the

business of insurance, Walgreen's, Sommers' and Rieger's participation in the Pharmacy Agreement is not the business of insurance.

For the reasons set forth herein, this Court does not agree with Plaintiffs' contentions. It is clear that the terms of the Policies which were reviewed by the State Board of Insurance and which it authorized Blue Shield to issue, expressly contemplate the execution of Pharmacy Agreements between Blue Shield and Participating Pharmacies. Moreover, the Pharmacy Agreement is so integrally related to the Policies that it would be impossible for Blue Shield to fulfill its contractual obligations to its insureds in the absence of such agreements.

The McCarran-Ferguson Act provides that ". . . the Sherman Act, . . . the Clayton Act, and the . . . Federal Trade Commission Act . . . shall be applicable to the business of insurance to the extent that such business is not regulated by State law." 15 U.S.C. § 1012(b). To the extent a state regulates such business by state law, the Sherman Act and the other federal antitrust laws are not applicable. The exemption is effective provided that two criteria are met: (1) that the "business of insurance" is involved, and (2) that there is state regulation of the business of insurance. The McCarran-Ferguson Act does not apply to acts of "boycott, coercion or intimidation." 15 U.S.C. § 1013(b).

II.

The Business of Insurance

In *SEC v. National Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564, 21 L.Ed.2d 668 (1969), the Supreme Court held that the "business of insurance" includes the relationship between the insurer and insured; the type of policy which could be issued, its reliability, interpretation and enforcement; and other activities of insurance companies which closely relate to their status as reliable insurers. *Id.* at 460,

89 S.Ct. 564. The Pharmacy Agreement directly pertains to the relationship between Blue Shield and its insureds. Moreover, the Pharmacy Agreement is a *direct* contractual relationship between the insurer and a provider of benefits, the result of which is simply the performance of the insurer's obligations owed to its insureds under the insurance contract and nothing more. A similar *direct* contractual relationship was examined in *Travelers Ins. Co. v. Blue Cross of West. Pennsylvania,* 481 F.2d 80 (3rd Cir. 1973) *cert. denied,* 414 U.S. 1093, 94 S.Ct. 724, 38 L.Ed.2d 550 (1973). In that case, the Third Circuit held that such contractual arrangements constituted the business of insurance, and thus, the relationship fell within the McCarran-Ferguson exemption. Direct contractual relationships between the insurer and a provider of benefits, as in this case, plainly relate to the "relationship between insurer and insured." The Pharmacy Agreement is based upon the provisions contained in the Policies relating to coverage and benefits, and directly concerns matters of interpretation and enforcement of the Policies. Clearly, the method adopted by Blue Shield of providing benefits under the Policies is closely connected to the relationship between Blue Shield and its insureds. The activities challenged by Plaintiffs in this action, including Blue Shield's contractual arrangements with Participating Pharmacies, constitute the business of insurance within the meaning of *SEC v. National Securities, Inc., supra.*

A program substantially similar in concept and operation to the one at issue was previously determined by the Texas Attorney General to constitute the business of insurance in the State of Texas. In response to a request for an opinion from the Texas Commissioner of Insurance, the Attorney General analyzed a prescription drug program which contemplated the filling of subscriber's prescriptions by participating pharmacies. The plan of operation was based upon a contract between the company and participating pharmacies, whereby the pharmacy agreed to charge

the subscriber no more than a certain percentage of the retail price of the prescription, and the company agreed to reimburse the pharmacy for the remainder. After thoroughly discussing the program the Attorney General concluded that ". . . the plan of operation intended to be followed by Prepaid Prescription Plan, Inc. would involve the doing of an insurance business in this state". Texas Attorney General's Opinion No. WW-1475 (Dec. 11, 1962).

This Court concludes that Blue Shield's plan of operation under the prescription drug insurance Policies, including the Pharmacy Agreements, constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act.

III.

State Regulation

A. *General Regulation.*

The McCarran-Ferguson Act renders the federal antitrust laws inapplicable when state legislation generally proscribes, permits, or otherwise regulates the conduct in question and authorizes enforcement through a scheme of administrative supervision. *Crawford v. American Title Ins. Co.,* 518 F.2d 217 (5th Cir. 1975); *FTC v. National Cas. Co.,* 357 U.S. 560, 78 S.Ct. 1260, 2 L.Ed.2d 1540 (1958); *Commander Leasing Co. v. Transamerica Title Ins. Co.,* 477 F.2d 77 (10th Cir. 1973).

The State of Texas has actively regulated the activities challenged in Plaintiff's Complaint since the inception of Blue Shield's prescription drug insurance program. The requirement of Article 3.42 of the Texas Insurance Code that all policy forms must be filed for review and approval by the State Board of Insurance prior to issuance or use by the insurer was fully satisfied. Active regulation of the prescription drug insurance program is further shown by the written orders issued by the Commissioner of Insurance and by the fact that the Texas Attorney General was

also kept fully advised of Blue Shield's prescription drug insurance program.

B. *Regulation Of Unfair Methods Of Competition In The Business of Insurance.*

Not only is there a scheme of general state regulation of the business of insurance involved in this action, but the Texas Insurance Code contains specific provisions applicable to the conduct alleged in Plaintiffs' Complaint. In 1951, the Texas Legislature enacted Tex.Ins.Code Ann. art. 21.21, which expressly regulates unfair competition and unfair practices in the business of insurance. The declaration of purpose of the Act states:

> "The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress) [the McCarran-Ferguson Act], by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined." Tex.Ins.Code Ann. art. 21.21 § 1.

Article 21.21 specifically prohibits "*any* trade practice which is defined in [the] Act as, or determined pursuant to [the] Act to be, an unfair method of competition or unfair or deceptive act or practice in the business of insurance." Tex.Ins.Code Ann. art. 21.21 § 3. (Emphasis added) That statute grants specific administrative and supervisory powers to the State Board of Insurance, including the power to issue cease and desist orders. Penalties are provided for violation of such orders. Without doubt, the phrase "any" unfair method of competition encompasses the conduct challenged in this action. Furthermore, the oral deposition testimony establishes that the State Board of Insurance reviews all policy forms submitted to it with a view toward

insuring compliance with Article 21.21, and that approved, as well as exempted policies, are subject to its provisions. Article 21.21 was specifically intended by its drafters to respond to the invitation of the McCarran-Ferguson Act and to withdraw from federal control the very conduct charged by Plaintiffs in this action, and to place such conduct under state control. Article 21.21 constitutes sufficient state regulation to activate the exemption provided in the McCarran-Ferguson Act. *Crawford v. American Title Ins. Co.*, 518 F.2d 217 (5th Cir. 1975); *Dexter v. Equitable Life Assurance Soc'y of the U. S.*, 527 F.2d 233 (2nd Cir. 1975).

C. *The Texas Antitrust Laws.*

In addition to the comprehensive regulation of Blue Shield's activities provided by the Texas Insurance Code, anticompetitive practices in the business of insurance are also regulated by the Texas antitrust laws. The Texas antitrust laws declare categorically that "[e]very monopoly, trust, and conspiracy in restraint of trade . . . is illegal and prohibited." Tex.Bus. & Comm. Code Ann. § 15.04(a). Further, the Texas antitrust laws specifically prohibit conspiracies of the type alleged in Plaintiffs' Complaint. Tex. Bus. & Comm.Code Ann. § 15.02. It should be noted that Plaintiffs have included in their Complaint a pendent claim under the Texas antitrust laws based upon the same facts that Plaintiffs allege give rise to a violation of the federal antitrust laws.

The existence of a state antitrust law proscribing the conduct complained of constitutes "regulation" within the meaning of the McCarran-Ferguson Act sufficient to displace the federal antitrust laws. *Meicler v. Aetna Cas. and Sur. Co.*, 506 F.2d 732 (5th Cir. 1975); *Sanborn v. Palm*, 336 F.Supp. 222 (S.D.Tex.1971); *Transnational Ins. Co. v. Rosenlund*, 261 F.Supp. 12 (D.Ore.1966); *California League of Ind. Ins. Producers v. Aetna Cas. & Sur. Co.*, 175 F.Supp. 857 (N.D.Cal.1959).

Therefore, in addition to active regulation under the Texas Insurance Code, the existence of state antitrust statutes forbidding the conduct alleged by Plaintiffs constitutes state regulation of the business of insurance sufficient to bar application of the federal antitrust laws.

IV.

The Boycott Exception to the McCarran-Ferguson Act Is Inapplicable

As in *Meicler v. Aetna Cas. and Sur. Co., supra,* Plaintiffs attempt to avoid the effect of the McCarran-Ferguson exemption by relying on the Section 1013(b) boycott exception. Plaintiffs' reliance on this exception is misplaced. The courts have narrowly construed Section 1013(b), which provides:

> "Nothing contained in this chapter shall render said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion or intimidation." 15 U.S.C. § 1013(b).

The sole purpose of this exception is to protect against the issuance of black-lists naming insurance companies or agents, rather than the conduct alleged by Plaintiffs in this action.

In *Meicler*, the Court stated:

> "As the district court noted, the legislative history indicates that the boycott exception was designed to reach insurance company 'black-lists' rather than refusal to sell to a particular segment of the public at other than a specified price. (Citations omitted) Appellants' broad construction of Section 1013(b) would emasculate the antitrust exemption contained in Section 1012(b) of the McCarran-Ferguson Act. We affirm the district court's holding that the boycott exception does not apply." 506 F.2d at 734.

This case does not involve black-listing and the boycott exception is inapplicable. *Addrisi v. Equitable Life Ins. Assurance Soc'y of the U. S.*, 503 F.2d 725 (9th Cir. 1974); *Proctor v. State Farm Mut. Auto Ins. Co.*, 406 F.Supp. 27 (D.D.C.1975); *Mitgang v. Western Title Ins. Co.*, Trade Reg.Rep. (1974-2 trade cases) ¶ 75,322 at 98,024 (N.D.Cal. October 16, 1974); *Transnational Ins. Co. v. Rosenlund*, 261 F.Supp. 12 (D.Or.1966).

V.

Application of the McCarran-Ferguson Act to the Non-Insurance Company Defendants

Plaintiffs contend that Walgreen, Sommers and Rieger are not entitled to the protection afforded by the McCarran-Ferguson Act because they are not insurance companies. The exemption provided in the Act is not strictly limited to insurance companies. As shown herein, it is the "business of insurance" with which the Act is concerned.

Recent cases have allowed the exemption even though the challenged activities involved parties other than insurance companies. In *Travelers Ins. Co., v. Blue Cross of West. Pennsylvania*, 481 F.2d 80 (1973), the Court applied the exemption to contracts between the insurance company and hospitals. In *Schwartz v. Commonwealth Land Title Ins. Co.*, 374 F.Supp. 564 (E.D.Pa. 1974), the exemption was applied to a fee charged to sellers of real estate by title insurance companies and agents.

It is clear that it is the nature of the conduct involved which must be looked at in order to determine whether or not the exemption should be applied. In the instant case, Walgreen, Sommers and Rieger, by having contractually agreed with Blue Shield to provide the benefits set out in the Policy, have become an integral part of the overall scheme of insurance coverage which is regulated by state law. Such integration of the providers of benefits under the

Policies into the overall scheme places their actions under the Pharmacy Agreements within the "business of insurance", and they are therefore entitled to the protection afforded by the McCarran-Ferguson Act for it is clear that one cannot be brought within the web of potential liability under the Federal Antitrust laws for participation in the complained of activity if such activity is, as in the instant case, exempt by operation of the McCarran-Ferguson Act.

VI.

Plaintiff's Pendent Claims

As shown above, the complained of activities are exempt from the Federal Antitrust laws because of the McCarran-Ferguson Act. It is clear from the pleadings on file that jurisdiction over this action does not exist by reason of diversity of citizenship. If the Federal claims are dismissed prior to trial, it is within the ambit of this Court's discretion to decline to continue to exercise jurisdiction over the pendent state claims. No unusual circumstances are present in this case which would require the Court to retain jurisdiction over the pendent claims. *United Mine Workers of America v. Gibbs,* 383 U.S. 715, 86 S.Ct. 1130, 16 L.Ed.2d 218 (1966); *Lazier v. Weitzenfeld,* 505 F.2d 896 (5th Cir. 1975); *Kavit v. A. L. Stamm & Co.,* 491 F.2d 1176 (2nd Cir. 1974).

VII.

Conclusion

For the reasons set forth above, this Court concludes that the complained of activities constitute the "business of insurance". This Court further concludes that the State of Texas has regulated and is actively and effectively regulating such business of insurance within the meaning of the McCarran-Ferguson Act, and the Federal Antitrust laws are thereby rendered inapplicable. Accordingly, Defend-

ants' motions will be granted. As shown herein, this Court has considered matters outside the pleadings in arriving at its decision. In doing so, the essentials necessary to support the exemption have been found to exist. Therefore, it is appropriate that Defendants' motions shall be treated as Motions for Summary Judgment and disposed of as provided in Rule 56, Federal Rules of Civil Procedure. The foregoing Memorandum Opinion constitutes the Court's Findings of Fact and Conclusions of Law.

An Order consistent with the foregoing will be entered.

APPENDIX B

ROYAL DRUG COMPANY, INC., d/b/a Royal Pharmacy of Castle Hills and Disco Prescription Pharmacy, et al., Plaintiffs-Appellants,

v.

GROUP LIFE AND HEALTH INS. CO., a/k/a Blue Shield and/or Blue Cross-Blue Shield of Texas, et al., Defendants-Appellees.

No. 76-2746.

United States Court of Appeals, Fifth Circuit.

Aug. 8, 1977.

Rehearing and Rehearing En Banc
Denied Oct. 27, 1977.

Independent, nonparticipating pharmacies brought antitrust action against defendant participating pharmacies and group insurer providing prescription drug coverage policies. The United States District Court for the Western District of Texas, at San Antonio, 415 F. Supp. 343, John H. Wood, Jr., J., entered judgment for the defendants and the plaintiff pharmacies appealed. The Court of Appeals, James C. Hill, Circuit Judge, held that: (1) statutory exemptions to antitrust laws required strict construction, and (2) contractual agreement between insurer and participating pharmacies providing for a limited markup equal to policyholder's deductible for each prescription and providing for direct reimbursement of participating pharmacies as opposed to 75% reimbursement to insureds dealing with nonparticipating pharmacies did not constitute "business of insurance" within the exemption provision of McCarran Act.

Reversed.

1. Monopolies — 10

Statutory exceptions to antitrust laws are to be strictly construed. Sherman Anti-Trust Act, § 1 et seq., 15 U.S.C.A. § 1 et seq.; McCarran- Ferguson Act, § 1 et seq., 15 U.S.C.A. § 1011 et seq.

2. Monopolies — 18

Merely because challenged conduct has been engaged in by an insurance company does not dictate its characterization as the "business of insurance" under McCarran Act providing that the federal antitrust laws are applicable to business of insurance only to the extent it is not regulated by state law; question presented under Act is whether activities complained of are part of business of insurance which Congress sought to remove from federal regulation. McCarran-Ferguson Act, § 1 et seq., 15 U.S.C.A. § 1011 et seq.

See publication Words and Phrases for other judicial constructions and definitions.

3. Monopolies — 18

Every action taken by insurance company to enhance its status as a reliable insurer does not necessarily constitute "business of insurance" within meaning of McCarran Act excluding business of insurance from federal antitrust laws to the extent it is regulated by state law. McCarran-Ferguson Act, § 1 et seq., 15 U.S.C.A. § 1011 et seq.

4. Monopolies — 18

Agreement which does not otherwise constitute "business of insurance" is not automatically embraced within protection of McCarran Act simply because it benefits policyholders either directly or indirectly by the strengthening

financial condition of insurer. McCarran-Ferguson Act, § 1 et seq., 15 U.S.C.A. § 1011 et seq.

5. Monopolies — 18

Agreement between group insurer providing prescription drug coverage and participating pharmacies limiting markup of such pharmacies to the two-dollar deductible under each policy and providing for direct reimbursement of total cost less deductible from insurer, as opposed to insurer's reimbursement of its insureds of only 75% when dealing with nonparticipating pharmacies, did not constitute a part of the "business of insurance" and was not shielded from antitrust scrutiny under the McCarran Act, even though agreement may have had some effect on policyholders and rates. Sherman Anti-Trust Act, § 1 et seq., 15 U.S.C.A. § 1 et seq.; McCarran-Ferguson Act, § 1 et seq., 15 U.S.C.A. § 1011 et seq.

6. Insurance — 3.1

Federal courts generally give heavy weight to state's determination that an activity constitutes "business of insurance" for purpose of McCarran Act exemption. McCarran-Ferguson Act, § 1 et seq., 15 U.S.C.A. § 1011 et seq.

7. Monopolies — 18

Activity is not a part of "business of insurance" within an antitrust exemption provision of McCarran Act solely because it has impact, favorable or otherwise, on premiums charged by insurer, and practices do not become clothed with McCarran Act protection simply because insurance company has contracted to pay provider for products or services. McCarran-Ferguson Act, § 1 et seq., 15 U.S.C.A. § 1011 et seq.

Joel H. Pullen, Stephen F. Lazor, San Antonio, Tex., for plaintiffs-appellants.

Keith E. Kaiser, R. Laurence Macon, J. Burleson Smith, San Antonio, Tex., for Group Life & Health.

William C. Church, Jr., San Antonio, Tex., for Walgreen Texas Co.

Richard B. Moore, San Antonio, Tex., for Sommers Drug Stores Co.

Charles R. Shaddox, San Antonio, Tex., for Rieger-Medi-Save Pharmacies, Inc.

Appeal from the United States District Court for the Western District of Texas.

Before GOLDBERG and HILL, Circuit Judges, and KERR,* District Judge.

James C. HILL, Circuit Judge:

The plaintiffs in this civil antitrust action are eighteen independent pharmacy owners doing business in San Antonio, Texas.[1] Blue Shield is a Texas insurance company authorized by the State Board of Insurance of Texas to sell life, health and accident insurance. Three other defendants, Walgreen Texas Company, The Sommers Drug Stores Company and Rieger Medi-Save Pharmacies, Inc., also operate pharmacies in San Antonio, Texas.

The plaintiffs contend that the defendants have violated Section 1 of the Sherman Act, 15 U.S.C. § 1, by agreeing, combining and conspiring to fix the retail price of drugs and pharmaceuticals, and that the activities of the defendants have caused Blue Shield's insureds not to deal with certain

* Senior District Judge for the District of Wyoming, sitting by designation.

[1] Since the parties have been referred to in the briefs as plaintiffs and defendants, as they were in the district court, they will be so designated in this opinion. The defendant Group Life & Health Insurance Company will be referred to herein as Blue Shield.

of the plaintiffs, thereby constituting an unlawful group boycott. Plaintiffs also allege violations of Texas antitrust law over which the district court took pendent jurisdiction. The defendants affirmatively alleged in their answers that pursuant to the provisions of the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.*, ("McCarran Act") the complaint failed to state a claim upon which relief could be granted and that the district court lacked subject matter jurisdiction. On the basis of the McCarran Act, each defendant moved to dismiss the complaint pursuant to Rule 12(b), F.R.Civ.P. The defendants also moved that the court treat their motions as motions for summary judgment pursuant to Rule 56, F.R.Civ.P. Defendants further moved the court to dismiss the claims based upon state law if the court found there was not a proper cause of action based upon federal law. The district court held that: (1) the conduct complained of by the plaintiffs constitutes the business of insurance; (2) the State of Texas has regulated and is actively regulating such business of insurance within the meaning of the McCarran Act; (3) that the boycott exception to the McCarran Act is inapplicable to the instant case; and (4) that the federal antitrust laws are, therefore, rendered inapplicable. We reverse.

I. *The facts.*

Plaintiffs are challenging a plan of operation under which Blue Shield issues certain prescription drug insurance policies which entitle Blue Shield's insureds to purchase drugs from any pharmacy. If the pharmacy selected by the policyholder has entered into a written contract ("Pharmacy Agreement") with Blue Shield, the insured is required to pay only two dollars ($2.00), the amount of the drug deductible set forth in the policy. On the other hand, if the insured has his prescription filled by a pharmacy other than a Participating

Pharmacy, he is required to pay the full price charged by the pharmacy, as well as the $2.00 deductible, and then to apply to Blue Shield for reimbursement. Blue Shield will then reimburse the insured only for 75 percent of the usual and customary charge for the drug, less the $2.00 deductible.[2]

In 1969, Blue Shield sought approval from the Texas State Board of Insurance to begin issuing prescription drug insurance coverage. The Commissioner, however, disapproved the issuance or use of such a policy. The policy remained under the consideration of the Commissioner and in September, 1969, the Commissioner issued an order exempting the policy from the approval requirements of Texas law. The defendants contend that there is uncontradicted evidence showing that an exemption order exempts the policy from nothing more than the requirement of approval by the State Board of Insurance, and that exempted policies, as well as approved policies, are subject to all statutory requirements of the Texas Insurance Code and the continuing regulation, control and supervision of the State Board of Insurance.

When the Commissioner issued his orders concerning the plan, disapproving it in the first instance, and then exempting the plan, he advised the Texas Attorney General in writing of his actions on each occasion. After receiving the exemption order, Blue Shield made a statewide mailing to licensed pharmacies offering them the privilege of entering into the Pharmacy Agreement. As a result, Blue Shield has issued the policy to various groups and has entered into the Pharmacy Agreement with pharmacies throughout the State of Texas.

In 1974, Blue Shield entered into a health care agreement, which included prescription drug insurance, to provide insur-

[2] The usual and customary charge is established by Blue Shield and is determined by reference to its compilation of such charges.

ance benefits to groups in Bexar County, Texas. In order to implement this agreement, in September, 1974, a policy form virtually identical to the one submitted in 1969 was filed with the State Board of Insurance for approval prior to its issuance or use. This policy was approved in October, 1974. Subsequently, Blue Shield has issued the policy to various groups in Bexar County and has offered to virtually all licensed pharmacies in San Antonio the opportunity of entering into the Pharmacy Agrement. Nine of the plaintiffs in this case accepted Blue Shield's offer and now operate Participating Pharmacies. In recent years, the number of pharmaceutical sales covered by this policy have risen dramatically. For example, between early 1972 and October, 1975, there was a 3,100 percent increase in the number of pharmaceutical claims processed by Blue Shield under the policy. In October, 1975, Blue Shield was handling these claims at the rate of approximately 31,000 claims per month as compared with only 1,000 claims per month in early 1972.

For each sale made under the plan, a Participating Pharmacy is limited to a $2.00 markup, which is known as a "professional dispensing fee," irrespective of its actual acquisition cost for a particular drug. The plaintiffs note that, with respect to highly expensive drugs, the Pharmacy Agreement can result in a markup of no more than two percent, which will not even cover the interest on its investment in inventory.

II. *Summary of Contentions on Appeal.*

The plaintiffs argue that the retail sales price, as fixed in the Pharmacy Agreement between Blue Shield and the defendant pharmacy chains, has been set at a level below that at which small independent pharmacies can profitably conduct business. They claim that only large, high volume chains that sell many items in addition to drugs can

afford to operate pursuant to the Pharmacy Agreement. They also contend that the Agreement fixes the retail price of drugs at a level which eliminates the only effective means by which small independent pharmacies can compete with the large chains — the provision of services. They argue that, since signatories of the Pharmacy Agreement are limited to the same retail sales price whether they provide home deliveries, twenty-four service, or no service at all, the ability of the independents to compete is effectively destroyed. The plaintiffs contend that Blue Shield's plan of operation not only encompasses the fixing of prices in the defendant pharmacy chains, but it extends to the pharmaceutical industry as a whole. They contend that small independent pharmacies are given the choice of either signing the price fixing agreement or being forced out of business.

The plaintiffs also argue that there are two types of coercion of Blue Shield's subscribers inherent in the plan. First, the subscriber receives markedly reduced benefits if he patronizes a pharmacy that refuses to sign the price-fixing agreement. Although he would pay only the $2.00 drug deductible for each prescription filled by a participating pharmacy, he would ultimately pay an amount representing 25 percent of a reasonable charge for the drug, in addition to the $2.00 drug deductible, for each prescription filled by a nonsigning pharmacy. The plaintiffs also point out that the differential in benefits between participating and nonparticipating pharmacies is intended to coerce Blue Shield's policy holders not to patronize nonsigning pharmacies *in Texas* and thereby to coerce such pharamacies to sign the price-fixing agreement. This allegation is based on the policy itself, which provides that the subscriber will be reimbursed 100 percent of a reasonable charge for the drug, less the $2.00 drug deductible, when he patronizes a nonsigning pharmacy outside the State of Texas.

The plaintiffs also contend that there is a second and more subtle step to the coercion. If a pharmacy signs the Pharmacy Agreement and agrees to charge only the stipulated amount for drugs sold to Blue Shield subscribers, it will be reimbursed directly by Blue Shield in the amount of the acquisition cost, and the subscriber will be obligated to pay the pharmacy at the time of purchase only the $2.00 drug deductible. If the pharmacy has refused to sign the Agreement, however, Blue Shield will not deal with the pharmacy directly, and the subscriber must pay the entire retail sales price at the time of purchase, in addition to the $2.00 fee. After paying the entire sales price at the time of purchase, he must file a claim with Blue Shield seeking reimbursement. Thus, an insured has the additional burden of filing a claim for reimbursement, and he must accept reduced benefits in order to patronize the drug store of his choice.

Having made the above claims, the plaintiffs are immediately confronted with defendant's argument that its activities are exempt from the antitrust laws by virtue of the McCarran Act. The McCarran-Ferguson Act provides that the Sherman Act, the Clayton Act and the Federal Trade Commission Act shall be applicable to the business of insurance only "to the extent that such business is not regulated by state law."

Disputing the applicability of the McCarran Act exemption, the plaintiffs contend that a three-step analysis is necessary to determine whether an insurance company's challenged activities fall within the Act's exemption. First, they contend, the court must determine whether the challenged activities constitute the "business of insurance." Second, it must determine whether the activities in question are regulated by state law. Third, the court must determine

the presence or absence of boycott, coercion, or intimidation.[3] The latter requirement derives from Section 3(b) of the McCarran Act, which states as follows: "Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate or act of boycott, coercion or intimidation." 15 U.S.C. § 1013(b) (1970).

III. *Do the Defendants' Activities Constitute the Business of Insurance?*

[1, 2] The stepping off point of our analysis is the general principle that statutory exceptions to the antitrust laws "are to be strictly construed." *Abbott Labs v. Portland Retail Druggists Ass'n, Inc.*, 425 U.S. 1, 96 S. Ct. 1305, 47 L. Ed. 2d 537 (1976); *FMC v. Seatrain Lines, Inc.*, 411 U.S. 726, 93 S. Ct. 1773, 36 L. Ed. 2d 620 (1973). The notion that "our cases have repeatedly established * * * a *heavy presumption against* implicit [antitrust] exemptions" was recently reaffirmed in *Abbott Labs., supra.*[4] Moreover, it is clear that merely because challenged conduct has been engaged in by an insurance company does not dictate its characterization as the "business of insurance" under the McCarran Act. *SEC v. National Securities, Inc.*, 393 U.S. 453, 89 S. Ct. 564, 21 L. Ed. 2d 668 (1969). The question presented under the McCarran Act, therefore, "is whether the activities complained of, *even though they may be actions taken by an insurance company*, are part of the 'business of insurance'

[3] A negative finding for the first question obviates the necessity for a determination with respect to the second and third steps, and precludes application of the McCarran Act. *SEC v. Nat'l Securities, Inc.*, 393 U.S. 453, 89 S. Ct. 564, 21 L. Ed. 2d 668 (1969); *American General Insurance Co. v. FTC*, 359 F. Supp. 887 (S.D. Tex. 1973), *aff'd.*, 496 F. 2d 197 (5th Cir. 1974).

[4] Relying on this general principle, plaintiffs argue that if the challenged activities do not clearly constitute the business of insurance, they fall outside the McCarran Act's protective umbrella and are subject to the full force and effect of the antitrust laws.

which Congress sought to remove from federal regulation." *Fry v. John Hancock Mutual Life Ins. Co.*, 355 F. Supp. 1151, 1153 (N.D. Tex. 1973) (emphasis added).

In *National Securities* the Supreme Court held that the "business of insurance" included (1) "the relationship between insurer and insured," (2) "the type of policy which could be issued, its reliability, interpretation and enforcement;" (3) "other activities which relate * * * to their status as reliable insurers." Relying on the first of these definitions, the plaintiffs note that the McCarran Act's focus is on the relationship between the insurer and the insured. The plaintiffs argue that a crucial determination is the question how closely the challenged activity concerns the relationship between the insurance company and the policyholder. The activities challenged herein, according to the plaintiffs, relate primarily to relationships other than that between the insured and its policyholders and therefore are not peculiar to the insurance industry. The plaintiffs concede that there may be effects on policyholders resulting from the Pharmacy Agreement, but they minimize these as peripheral and secondary to the effects on the relationships between competing pharmacies and between such pharmacies and their customers.

[3, 4] The defendants contend, and the district court found, that the plan of operation followed by Blue Shield, including the Pharmacy Agreement, relates directly to its status as a reliable insurer. We cannot agree. It is beyond peradventure that every action taken by an insurance company to enhance its status as a "reliable insurer" does not necessarily constitute the "business of insurance" within the meaning of the McCarran Act. Moreover, an agreement which does not otherwise constitute the business of insurance is not automatically embraced within the protection

of the McCarran Act simply because it benefits policyholders either directly, or indirectly by strengthening the financial condition of the insurer.

[5] Defendants allege that the contractual arrangements between Blue Shield and Participating Pharmacies require nothing more than the performance of obligations owed to Blue Shield's insureds under the drug insurance policies. In concluding that "[t]he Pharmacy Agreement directly pertains to the relationship between Blue Shield and its insureds," the district court held that the Pharmacy Agreement "is simply the performance of the insurer's obligations owed to its insureds under the insurance contract and nothing more." Despite these characterizations of the contractual arrangement, we find that the agreements between Blue Shield and Participating Pharmacies do not require Blue Shield to fix prices or to produce other anticompetitive effects in the pharmaceutical industry. Blue Shield's sole obligation is to see that the insured receives prescription drugs and "shall be required to pay no more than the drug deductible for each of such covered drugs." It is unnecessary for Blue Shield to agree with pharmacies to fix retail sales prices in the pharmaceutical industry. Blue Shield's policyholders are basically unconcerned with the contract between the insurer and the Participating Pharmacy. They are obligated to pay a Participating Pharmacy two dollars ($2.00) for a prescription regardless of the presence or absence of a price fixing arrangement. Thus, by minimizing costs and maximizing profits, the Participating Pharmacy Agreements inure principally to the benefit of Blue Shield.

The plaintiffs attempt to illustrate by example that the relationship primarily affected by the Pharmacy Agreement and the alleged coercion is that between competing pharmacies and not the relationship between insurer and insured.

If the challenged activities in this case are held to constitute the business of insurance, they contend, then automobile insurers will be able to utilize Participating Repair Shop Agreements and coercion to fix prices for parts and labor in the automobile industry. Similarly, they contend that fire insurance companies would be able to execute Participating Construction Company Agreements and thereby combine and conspire with large construction companies to set prices for the repair and rebuilding of homes or buildings damaged by fire. The plaintiffs contend that Congress never intended that the McCarran Act be utilized to shield such activities from application of the federal antitrust laws. They note that Congress, in enacting the McCarran Act, may have condoned state supervised rate setting, but Congress was opposed to private price fixing and did not intend that such activity be shielded from federal scrutiny.

The defendants argue that the Pharmacy Agreement is so inextricably intertwined with the policies that it would be impossible for Blue Shield to fulfill its contractual obligations to its insureds in the absence of such agreements with the pharmacies. The defendants also dispute plaintiffs' arguments that if Blue Shield's activities are permitted, automobile insurers will utilize Participating Repair Shops and fire insurance carriers will enter into Participating Construction Company Agreements. The defendants contend that the types of insurance referred to by the plaintiffs are not at issue here and such types of insurance are regulated by the provisions of the Texas Insurance Code which are not similar to the ones involved in this case. They also contend that Blue Shield was statutorily required to submit the policies to the state board prior to issuance or use and that the Commissioner authorized the use of the policy and Pharmacy Agreement. Finally, they contend that the activities suggested in the hypothetical examples would require

careful examination of the existing laws and regulatory devices relating to automobile insurance and fire insurance. In short, they contend that these hypotheticals are nothing more than speculation and conjecture.

We conclude that Blue Shield is no more obligated to fix the retail prices of pharmaceuticals than an automobile insurer is obligated to its insureds having deductible policies to fix the prices charged for parts and labor. Just as the automobile insurer is obligated to pay the cost of repair, whatever it might be, over and above the applicable policy deductible, Blue Shield is obligated to pay the cost of prescription drugs over and above the two dollars ($2.00) drug deductible. Even though an automobile insurer might be able to guarantee by contract that repairs are done for its customers on a "cost" basis, thereby achieving increased profits or reduced rates, such agreements do not thereby become immune from antitrust scrutiny. *Contra, Proctor v. State Farm Mutual Insurance Co.*, 406 F. Supp. 27 (D.D.C. 1975).

The plaintiffs next contend that the Pharmacy Agreement produces results far beyond the simple performance of Blue Shield's responsibilities owed to its insureds under The Prescription Drug Insurance Policy. Blue Shield itself may have recognized that the Pharmacy Agreement goes beyond its obligations under the prescription plan. The plaintiffs introduced into evidence a letter between two Blue Shield executives which indicated a concern over antitrust problems and suggested that the company camouflage the price fixing arrangement as a "mass accounting agreement." The evidence introduced in the trial court stated as follows: "I think it would be best to draft the contract so that the Insurance Board would require filing of the mass accounting agreement [Pharmacy Agreement] to strengthen your base on anti-

trust. Drafting problems will get sticky here, but let's pass on that for now." The plaintiffs contend that this letter carries the Blue Shield plan far beyond the protection of the McCarran Act. They contend that Congress did not contemplate or intend that the McCarran Act should shield from antitrust scrutiny any insurance company's efforts to control the magnitude of its policyholder's claims through the elimination of price and other forms of competition in the industries providing goods and services covered by the insurance policy. Since these activities are not regulated by the State, they contend that the McCarran Act exemption does not apply.

We find that the Pharmacy Agreement goes beyond Blue Shield's obligations as an insurer and places the firm in the business of providing products and services. Blue Shield has agreed to provide protection against the risk that a policyholder will require pharmaceuticals. In order to meet that obligation, Blue Shield is not required to guarantee the provision of services on a "cost-plus" basis or any other basis which might be more economical than the retail purchase of such products. That Blue Shield may wish to protect itself and its customers from rising costs in the pharmaceutical industry does not transform the Pharmacy Agreement into the business of insurance. In fact, the best way for the firm to protect itself from rising costs is to establish and periodically adjust its rate structure to reflect the impact of inflation. Such measures, which are by no means foreign to the insurance business, involve far less intrusion into the pharmaceutical industry and, consequently, avert the potentially anticompetitive effects alleged here.

The plaintiffs next attempt to come to grips with *Travelers Insurance Company v. Blue Cross*, 481 F. 2d 80 (3rd Cir.), *cert. denied*, 414 U.S. 1093, 94 S. Ct. 724, 38 L. Ed. 2d

550 (1973), by arguing that the McCarran Act does not apply *ipso facto* to every direct contractual relationship between an insurance company and a provider of benefits. In *Travelers*, the Third Circuit held that the contractual arrangements consummated between Blue Cross and various hospitals for the furnishing of services under insurance policies constituted the business of insurance and, thus, the relationship fell within the McCarran Act exemption. There, as here, the relationship was a direct contractual relationship the result of which was the performance of obligations owed to the insured by the insurer on an economically favorable basis. The plaintiffs have attempted to distinguish *Travelers* by arguing that the Third Circuit was merely approving the actions of the Insurance Commissioner of Pennsylvania who was exerting pressure on the large insurance companies to exercise their power over hospitals to reduce hospital costs. This interpretation, with which we agree was adopted in *Doctors, Inc. v. Blue Cross*, 431 F. Supp. 5 (E. D. Pa. 1975), *aff'd. per curiam*, 557 F. 2d 1001 (3d Cir. 1976).[5] Moreover, the *Travelers* decision was based in large measure on the Pennsylvania legislature's control over rates charged by nonprofit hospitals. That regulation was undertaken pursuant to a statutorily created interrelationship between the rates charged by nonprofit health insurers and nonprofit hospitals, which interrelationship was to be regulated by the Pennsyl-

[5] The court indicated the narrow scope of *Travelers* as follows:
It is therefore readily apparent from the reading of the *Travelers* case that the Third Circuit is approving the *actions of the Insurance Commissioner of Pennsylvania when he exerts pressure* on the large insurance companies to get them to exercise their power over hospitals to force the hospitals to cut costs wherever possible. This is exactly what Blue Cross was doing in our case at the bequest of the Insurance Commissioner. Therefore, since the McCarran-Ferguson exemption was applicable in Travelers * * *, I hold today that the McCarran-Ferguson exemption is applicable in *Doctors, Inc.* * * *. *Doctors, Inc. vs. Blue Cross*, 431 F. Supp. 5, 10 (E.D. Pa. 1975), *aff'd* 557 F. 2d 1001 (3d Cir. 1976) (emphasis added).

vania Insurance Department. The plaintiffs note that the Texas Legislature has not chosen indirectly or directly to control the rates charged by pharmacies either by directing and controlling contracts between insurers and pharamacies or by creating an interrelationship between the rates charged by pharmacies and those charged by insurers. Since *Travelers* held simply that the contract between a nonprofit health insurer and a nonprofit hospital was shielded by the McCarran Act from attack, *Travelers* carries little precedential value in this appeal.

Rather, the instant case is more nearly akin to *Battle v. Liberty Nat'l Life Ins. Co.*, 493 F. 2d 39 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110, 95 S. Ct. 784, 42 L. Ed. 2d 807 (1975). In *Battle* several funeral homes and directors brought suit against an insurer, which issued burial policies, and the insurer's wholly owned subsidiary, which supplied merchandise and services required by the insurer's policies. Although this court found coercion with respect to the insurer's discrimination in benefits, the court felt that the facts were inadequately developed to make a conclusive determination on the McCarran Act issue. Nonetheless, the court stated as follows: "[I]t might be plausibly argued that these facts do not constitute the business of insurance as contemplated by the McCarran Act and thus do not fall within its exemption."[6] The court noted that the obligations under the insurer's arrangement might be related to the business of insurance, but the obligations were so remotely

[6] The Court stated:
It appears that, since the insurance contract confers far more benefits upon the policyholder if he uses an authorized funeral home, the policyholder is subtly coerced into dealing only with the authorized home. The imposition of this restraint would effectively foreclose the unauthorized funeral director's access to a substantial portion of the market. 493 F. 2d at 44-45.
The court held that these facts "if established, would tend to support a finding of unreasonable restraint of trade." 493 F. 2d at 44.

related as to be subject to the antitrust laws. Relying on *Battle*, the plaintiffs argue that the defendants' activities challenged herein are not peculiar to the insurance industry and are not the business of insurance. They argue that by providing markedly decreased benefits to those subscribers who patronize a nonparticipating pharmacy, Blue Shield intentionally and overtly coerces its subscribers to boycott these pharmacies. Not only does this boycott operate to coerce the nonsigning pharmacies to participate in the plan, it also forecloses nonsigning pharmacies from a significant portion of the market and secures for participating pharmacies the sales of prescription drugs required by Blue Shield's claimants. Since this activity is not peculiar to the insurance industry, plaintiffs argue that it does not constitute the business of insurance. As in *Battle*, the contractual agreements here under review are somewhat related to the business of insurance. The relationship, however, is so attenuated that it must be subject to the antitrust laws. As the plaintiffs have so well articulated, "it is not the office of the insurance industry to set the prices in the various sectors of our economy so that insurers will enjoy an added measure of control over the magnitude of individual claims."

[6] The plaintiffs next take issue with the finding of the district court that a 1962 Opinion of the Texas Attorney General has concluded that the challenged activity constitutes the business of insurance. The court read the 1962 Opinion as a determination by the Texas Attorney General that a plan "substantially similar" to Blue Shield's plan constituted the business of insurance. Plaintiffs contend that the Attorney General's Opinion held only that the particular firm in question was an insurance company and not that a program substantially similar to Blue Shield's constituted the business of insurance. The plaintiffs allege that the

Attorney General's Opinion was based strictly on the facts presented and that it bears no logical relevance to the question whether the activities challenged in this suit constitute the business of insurance. Although the 1962 Opinion is not without ambiguity, it appears to focus on the status of the company itself; it does not conclusively establish whether the State considers a plan such as Blue Shield's Pharmacy Agreement to constitute "the business of insurance." Thus, we are compelled to eschew the heavy weight usually given a state's determination that an activity constitutes the "business of insurance" in favor of the interpretation given the term by the federal courts. See *SEC v. Variable Annuity Co.*, 359 U.S. 65, 69, 79 S. Ct. 618, 3 L. Ed. 2d 640 (1959).

The State has shed very little light on this matter since the 1962 Attorney General's Opinion discussed above. Although the plaintiffs argue that the State Board of Insurance does not consider The Pharmacy Agreement to encompass or constitute the business of insurance, it is by no means clear that the State has even considered the question. The district court concluded that "[t]he State of Texas has actively regulated the activities challenged in plaintiff's complaint since the inception of Blue Shield's Prescription Drug Insurance *Program*." (emphasis added). Plaintiffs contend that the district court uses the word "program" loosely in that the Board of Insurance approved nothing more than the insurance policy itself and it did not consider the Pharmacy Agreement, which is at issue in this case.

It is clear from the record that the Board has never approved the Pharmacy Agreement, and the Division Manager of the Board's Policy Approval Division, a Mr. Pogue, testified that he thought the Pharmacy Agreement was outside of the State's regulatory control. He stated as follows: "I

do not feel that a contract of that nature falls within the jurisdiction of the State Board of Insurance." Plaintiffs argue that the Pharmacy Agreement does not fall within the jurisdiction of the State Board of Insurance simply because it does not constitute the business of insurance.

There is some testimony which contradicts the testimony of Mr. Pogue. A former employee of the State Board of Insurance, a Mr. Connor, gave an arguably contradictory response to what the plaintiffs describe as a "convoluted question" concerning the exemption of Blue Shield's Prescription Drug Insurance Policy form. With respect to this exemption, the following exchange took place between counsel for Blue Shield and Mr. Connor:

> Q. [By Mr. Kaiser] * * * Mr. Connor, at the time of the issuance of this Exemption Order that you are looking at right now, was it your opinion that this particular contract which is marked Deposition Exhibit 52 [the Prescription Drug Insurance Policy], along with the Participating Drug Pharmacy Agreement which Blue Shield proposed to issue, was it your opinion *that that* constituted the business of insurance?
>
> A. [Mr. Connor] Yes.

Plaintiff concedes that one might draw from this exchange that Connor thought the Pharmacy Agreement was a part of the business of insurance. Plaintiffs argue, however, that the phrase "that that" leaves the issue in doubt because Connor may have understood the phrase "that that" to refer only to the policy itself and not to the Pharmacy Agreement. This position is bolstered by Connor's earlier testimony, wherein he stated that he did not recall having occasion to review the Pharmacy Agreement before drafting the Exemption Order and that he had "no recollection of receiving the document."

The testimony of these officials, therefore, at best raises a factual issue concerning the State's position. It, like the 1962 Attorney General's Opinion, is not a definitive statement of the State's position.

The defendants nonetheless place great emphasis on the extent of state regulation and attempt to minimize plaintiff's arguments concerning the "business of insurance." They rely on *Crawford v. American Title Ins. Co.*, 518 F. 2d 217 (5th Cir. 1975), where this court held that pervasive regulation by the State of Alabama over antitrust matters in the insurance industry precluded application of the federal antitrust laws. The problem with the defendants' position is that the McCarran Act applies only when the activity concerned is the business of insurance *and* the activity is regulated by the State. In *Crawford* there was no question that the challenged conduct constituted the business of insurance; rather, the issue was the extent and pervasiveness of state regulation. There seems to be no question that the State of Texas regulates the insurance industry quite vigorously, but there is no similar indication that the activities complained of are considered the business of insurance by the State or by any common sense interpretation of that term.[7]

We recognize that several district courts have rendered decisions contrary to the conclusion we reach today. *Manasen v. California Dental Services*, 424 F. Sup. 657 (N.D. Cal. 1976); *Proctor v. State Farm Mutual Insurance Co.*, 406 F. Supp. 27 (D.D.C. 1975); *Schwartz v. Commonwealth Land Title Insurance Co.*, 374 F. Supp. 564 (E.D. Pa. 1974), sub-

[7] The McCarran Act likewise affords no antitrust exemption to the so-called noninsurance company defendants who are parties to this litigation. Indeed, it would be highly anomalous for this court to conclude that the sale of pharmaceuticals by these defendants constitutes the "business of insurance" for purposes of federal antitrust law.

sequent proceedings reported at 384 F. Supp. 302 (E.D. Pa. 1974); *Nankin Hospital v. Michigan Hospital Service*, 361 F. Supp. 1190 (E.D. Mich. 1973); *California League of Independent Insurance Producers v. Aetna Casualty & Surety Co.*, 175 F. Supp. 857 (N.D. Cal. 1969). Indeed, two such cases have been affirmed on appeal. *Anderson v. Medical Service of the District of Columbia*, 551 F. 2d 304 (4th Cir. 1977); *Frankford Hospital v. Blue Cross*, 554 F. 2d 1253 (3d Cir. May 2, 1977). Perhaps the most far-reaching of these is the *Manasen* case, in which the district court concluded that the McCarran Act exemption applied to a nonprofit corporation engaged in the administration and operation of prepaid dental care programs. The defendant corporation administered prepaid dental care plans under agreements and contracts with various subscriber groups and subscribing purchasers, including governmental bodies, employer organizations, and joint employer-labor trust funds. The subscribers paid periodic premiums to CDS in exchange for future dental services performed for individuals on whose behalf the premiums were paid.

[7] Professional services were performed by practicing dentists who were classified by CDS as "participating" or "nonparticipating" dentists. In order to attain the "participating" status, a dentist was required to look solely to CDS for payment and to set patients' fees at levels not in excess of the amounts established in a CDS approved fee schedule. Any dentist who did not agree to limit his fees to the range specified by CDS would be classified by the corporation as "nonparticipating." Covered patients who selected participating dentists to perform services would receive full benefits under the program. Patients seeking care from nonparticipating dentists, however, would receive less than the full benefits from CDS. The plaintiffs alleged that this arrangement had

the effect of excluding nonparticipating dentists from the CDS market since a CDS patient who sought services from a nonparticipating dentist suffered a financial detriment. Although the defendant corporation was not an insurance company, the court concluded that it was engaged in the business of insurance for McCarran Act purposes. The court placed considerable weight on the favorable impact of the arrangement on the company's insurance rates:

> It is undisputed that the level of dentists' fees are a major factor in determining policy premiums. CDS' payment arrangements to service providers are critical elements in CDS' contractual agreements with its subscribers. These arrangements are intimately related to the interpretation and implementation of CDS' policies and to its reliability as an insurer. Accordingly, the Court finds that the activities challenged in the instant complaint constitute part of the "business of insurance" within the meaning of the McCarran Act.

424 F.Supp. at 666—67 (footnote omitted).

We find ourselves in serious disagreement with the rationale underlying the *Manasen* decision. An activity is not a part of the business of insurance solely because it has an impact, favorable or otherwise, upon premiums charged by the insurer. Monopolistic or coercive activities in "provider industries" may often have a favorable economic impact upon the rates or the costs of insurance companies. But such practices do not become clothed with McCarran Act protection simply because an insurance company has contracted to pay the provider for products or services.

In *SEC v. Nat'l Securities Inc., supra*, the Supreme Court held that the activity of two insurance companies in merging did not constitute the business of insurance, despite the fact the transaction undoubtedly affected policyholders in terms

of the security of their insurance contracts and the reliability of their insurers. Moreover, business activities of insurance companies not peculiar to the insurance industry are outside the scope of the McCarran Act. *Center Ins. Agency v. Byers*, (N.D. Ill. 1976); *American Family Life Assurance Co. v. Planned Marketing Associates*, 389 F. Supp. 1141 (E.D. Va. 1974); *American General Ins. Co. v. FTC*, 359 F. Supp. 887 (S.D. Tex. 1973), *aff'd* 496 F. 2d 197 (5th Cir. 1974). As indicated by the activities of the noninsurance company in *Manasen, supra*, the activity complained of by plaintiffs is not peculiar to the insurance industry. To be sure, price fixing and coercion induced by firms with superior bargaining power are often found in all industries. Thus, Blue Shield's attempts to control costs in the pharmaceutical industry might just as easily be undertaken by a noninsurance firm attempting to meet a contractual obligation to deliver drugs to a wholesale or retail purchaser.

Manasen and other cases have emphasized the favorable impact that price fixing and coercion have had on insurance premiums and the "reliability" of the insurers. It is conceivable that the public might benefit from price fixing arrangements as long as the parties to the arrangement agree to keep prices below free market levels. The Congress, however, has foreseen that the power to fix prices might not always be beneficially administered by those parties holding the power once their competition has been put out of business. It is quite clear that competitors can be destroyed by those whose financial resources permit them to reduce prices until their competition is eliminated, only for the purpose of raising prices in the long run. Whether such economic coercion is proper is not for a court to decide. It is a matter of national policy which has been addressed by the Congress, from which any change will originate only after appropriate

investigation, hearings and deliberation. We apply the law as presently determined by the Congress and we hold that the antitrust laws are applicable to the arrangements challenged herein.

We conclude, therefore, that Blue Shield's Pharmacy Agreement is not a part of the business of insurance and is not shielded from antitrust scrutiny even though it may have some effect upon the company's policyholders and rates.

REVERSED.

Supreme Court, U.S.
FILED
MAY 12 1978
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

---

BRIEF FOR PETITIONERS

Petitioners Group Life and Health Insurance Company, Rieger/Medi-Save Pharmacies, Inc., Walgreen Texas Co. and The Sommers Drug Stores Company request this Court to reverse the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the United States District Court for the Western District of Texas is reported at 415 F. Supp.

343. The opinion of the United States Court of Appeals for the Fifth Circuit is reported at 556 F.2d 1375. The District Court and Court of Appeals opinions are reproduced at pages 100a-115a and 117a-138a of the Appendix ("App.").

JURISDICTION

The judgment of the Court of Appeals was entered on August 8, 1977. (App. 139a) A Petition For Rehearing And Rehearing *En Banc* was denied on October 27, 1977. (App. 140a) A timely Petition For A Writ Of Certiorari was filed on January 3, 1978, and certiorari was granted on February 27, 1978. The jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

STATUTES INVOLVED

The provisions of the McCarran-Ferguson Act ("McCarran Act") involved in this case, §§ 1-3, 59 Stat. 33 (1945), 15 U.S.C. §§ 1011-1013 (1976), are set forth in the Addendum.[1]

QUESTION PRESENTED

The question presented is whether the "business of insurance," within the meaning of the antitrust exemption afforded by the McCarran Act, includes a contract between an insurer and a health care provider to furnish benefits owed to policyholders under the insurer's health care policies.

STATEMENT OF THE CASE

Petitioner Group Life and Health Insurance Company, also known as Blue Shield of Texas ("Blue Shield"), is

[1] Pertinent provisions of the Texas Insurance Code and antitrust statutes are also incorporated in the Addendum ("Add.").

an insurance company duly authorized by the Texas State Board of Insurance to transact the business of life, health and accident insurance within the State of Texas.[2] (App. 433a, 471a-472a) Petitioners Rieger/Medi-Save Pharmacies, Inc., Walgreen Texas Co. and The Sommers Drug Stores Company (the "pharmacy petitioners") own and operate pharmacies in San Antonio, Texas. (App. 14a, 19a, 31a)

Respondents, plaintiffs below, are eighteen pharmacy owners and operators also doing business in San Antonio. (App. 2a-5a) Respondents' antitrust action for treble damages and injunctive relief challenges certain aspects of Blue Shield's prepaid prescription drug insurance program. Specifically, respondents attack the contracts between Blue Shield and pharmacies under which the pharmacies provide drugs to Blue Shield's insureds and are reimbursed by Blue Shield.

The United States District Court for the Western District of Texas determined that Blue Shield's insurance plan, including the pharmacy contracts, constituted the "business of insurance" and was exempt from the Sherman Act by virtue of the McCarran Act. The United States Court of Appeals for the Fifth Circuit reversed, holding that Blue Shield's pharmacy contracts were not

[2] Blue Shield is a legal reserve stock insurance company organized under Chapter 3 of the Texas Insurance Code, *Tex. Ins. Code Ann.* art. 3.01 *et seq.* (1963). (*See also* Depo. of Donald H. Bunnell ("Bunnell Depo."), App. 423a) [Mr. Bunnell is Manager of the Company License Section of the Texas State Board of Insurance, having responsibility for licensing insurers, authorizing types of coverage and supervising insurers' financial condition. (App. 422a)] All of the stock of Blue Shield, with the exception of a few qualifying shares, is owned by Group Hospital Service, Inc., a non-profit hospitalization insurer organized under Chapter 20 of the Insurance Code, *Tex. Ins. Code Ann.* art. 20.01 *et seq.* (1963). Group Hospital Service, Inc., is also known as Blue Cross of Texas. (Affidavit of Steve G. McDonald ("McDonald Aff."), App. 45a-46a)

the "business of insurance" within the contemplation of the Act.

A. The Challenged Provisions of Blue Shield's Prescription Drug Insurance Program

Blue Shield is in the business, *inter alia*, of selling prepaid prescription drug insurance policies. (App. 7a, 26a) These policies insure the policyholder against the risk of financial loss resulting from the purchase of drugs prescribed by his physician, and the possibility that the insured will be unable to afford such drugs. Prepaid drug policies are issued as part of group health insurance plans whereby Blue Shield (and, in some cases, Texas Blue Cross) insure employee groups for comprehensive health care benefits and employers pay part or all of the policy premiums. (Depo. of Steve G. McDonald ("McDonald Depo."), App. 296a. A copy of Blue Shield's "Drug Supplement Policy" is reproduced at App. 51a-58a.)

The policies in issue obligate Blue Shield to insure its policyholders against the cost of drugs in either of two ways: primarily by contractual arrangements with pharmacies who agree to provide prescription drugs to the insureds in exchange for reimbursement from Blue Shield; and secondarily by partial cash reimbursement to the policyholder for amounts expended in the purchase of drugs. The Participating Drug Pharmacy Agreement ("Pharmacy Agreement") attacked by respondents is the mechanism through which prescription drug benefits are provided to insureds in accordance with Blue Shield's obligations under the policy. (A copy of the Pharmacy Agreement is reproduced at App. 59a-61a.)

Blue Shield's insureds are entitled to obtain prescription drugs from any pharmacy they choose. (App. 166a) If the pharmacy selected has entered into a Pharmacy Agreement with Blue Shield (a "Participating Pharmacy"), the policy provides that the insured is required to pay no more than a $2.00 deductible for each prescription.[3] (App. 55a) The availability of Participating Pharmacies which agree not to charge the insured in excess of $2.00 is thus a benefit under the policies. Under the Pharmacy Agreement, a Participating Pharmacy agrees to dispense drugs to Blue Shield's insureds and to accept no more than $2.00 (the deductible) as full payment from the insured for each dispensed drug. (App. 60a, 175a) The Participating Pharmacy is then entitled to file a claim for additional reimbursement directly from Blue Shield. (App. 60a, 182a) Blue Shield agrees to reimburse the Participating Pharmacy for the acquisition cost of each dispensed drug, plus a dispensing fee of $2.00, minus the amount of the deductible.[4] (App. 60a, 175a) If the insured's prescription is filled by a pharmacy other than a Participating Pharmacy, the policy provides that Blue Shield will reimburse the insured for 75 percent of the "usual and customary charge" for the drug, after first subtracting the $2.00 deductible.[5] (App. 56a, 170a, 184a)

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[3] Participating Pharmacies are designated as "Participating Providers" in the policies, and are defined as those who "[have] entered into a written contract [with Blue Shield] for the rendition of covered drugs for which benefits are provided by this [policy] . . . ." (App. 54a)

[4] The total amount received by the pharmacy therefore is equal to the acquisition cost (received from Blue Shield) plus $2.00 (received from the insured). In 1974, Texas Blue Shield paid $1,145,342.22 in claims on a total of 308,128 prescriptions. Thus, the average prescription claim payment by Blue Shield was $3.72, in addition to which Participating Pharmacies received $2.00 per claim from the policyholder. (Depo. of Judith M. Johnson ("Johnson Depo."), "Out-of-Hospital Prescription Drugs Questionnaire" dated March 12, 1975, unnumbered Exhibit)

[5] The administrative costs of processing claims for drugs purchased from non-participating pharmacies are higher than for those purchased from participating pharmacies. In the former case, the insured typically sends in only a receipt for the prescription,

The opportunity of entering into a Pharmacy Agreement has always been available to all licensed pharmacies in Texas, including each of the respondents. (McDonald Aff., App. 48a; Johnson Depo., App. 151a-152a) Indeed, nine of the respondents operate Participating Pharmacies in the San Antonio area, as do the pharmacy petitioners. (App. 14a, 19a, 31a; McDonald Aff., App. 50a)

B. The History of the Drug Insurance Program

The insurance program here in issue had its origins in 1967, when the United Auto Workers and the three largest domestic automobile manufacturers entered into a collective bargaining agreement establishing a prepaid prescription drug program for U.A.W. members to become effective October 1, 1969. (McDonald Depo., App. 301a. A memorandum describing the U.A.W. plan is reproduced at App. 205a-275a.) The labor-management agreement explicitly required participating pharmacies to be used. (App. 205a) Michigan Blue Shield was the first insurer to offer the program (App. 242a, 245a, 249a), and Blue Shield of Texas subsequently agreed to provide the coverage for employees of Ford Motor Company and Chrysler Corporation living in Texas. (McDonald Depo., App. 296a-297a; Johnson Depo., App. 143a-144a)

In order to implement the program as required in the collective bargaining agreement, Blue Shield drafted a policy form and Pharmacy Agreement. In March, 1969,

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which does not contain sufficient information to process the claim. Thereafter, Blue Shield must correspond with the insured to obtain the additional information necessary to prepare a proper claim form. In addition, unlike claims information submitted by participating pharmacies, information received from insureds is not coded on special forms so as to allow direct input into Blue Shield's computers. The amount of work necessary to enter such information in data processing equipment is thus increased if an insured's prescription is filled by a non-participating pharmacy. (Depo. of Lee Helis ("Helis Depo."), App. 283a-284a)

in compliance with the requirements of Article 3.42 of the Texas Insurance Code, *Tex. Ins. Code Ann.* art. 3.42 (Supp. 1977) (Add. 2a-4a),[6] Blue Shield filed the proposed policy and the annexed Pharmacy Agreement with the Texas State Board of Insurance ("State Board") for approval. (App. 352a-353a; McDonald Depo., App. 297a) In June, 1969, the State Board issued an order disapproving the proposed policy and Pharmacy Agreement. (App. 365a-366a) While the disapproval order was in effect, Blue Shield did not issue or use either the policy or the Pharmacy Agreement. (McDonald Aff., App. 47a)

Following disapproval, however, the policy and Pharmacy Agreement remained under consideration by the State Board. (Depo. of Paul Connor ("Connor Depo."), App. 392a-393a)[7] In September, 1969, the Board issued another order, this time *authorizing* the issuance and use of the policy and the Pharmacy Agreement. (App. 370a-371a)[8] In pertinent part, the order provided that, effective upon issuance, the policy would:

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[6] Article 3.42 of the Code is a typical "prior approval" form of insurance regulation. It requires all life, health and accident insurers to file proposed policy forms with the Texas State Board of Insurance for approval prior to issuance or use by the company.

[7] Mr. Connor was employed by the State Board for twenty-three years. During the first ten years of his employment, he was General Counsel to the Board. During the remaining thirteen years he held the position of Deputy Commissioner of Insurance. (App. 388a-389a)

[8] The order was entered under Article 3.42(e) of the Insurance Code, *Tex. Ins. Code Ann.* art. 3.42(e) (Supp. 1977), which grants authority to the State Board to exempt "any insurance document or form" from the approval requirements of Article 3.42 when deemed it proper. (Add. 3a-4a) The order authorized Blue Shield to issue and use the policy in the State of Texas in the same manner as if an approval order had been entered. (Connor Depo., App. 401a; Depo. of A. W. Pogue ("Pogue Depo."), App. 332a; Depo. of R. C. McAnelly ("McAnelly Depo."), App. 417a) [Mr. Pogue is Manager of the Policy Approval Division of the State Board of Insurance, whose duties include approval of proposed policies filed under the pro-

> confer upon the policyholder the right to obtain certain prescribed drugs at a cost fixed in the contract, the *insurer having entered into participating agreements with dispensing pharmacies to supply the prescribed drugs to its policyholders.* [(App. 371a) (emphasis added)]

The policy and Agreement were authorized in part for the purpose of permitting Blue Shield to implement the provisions of the 1967 U.A.W. collective bargaining agreement. (Connor Depo., App. 392a-393a) The order remains in full force and effect. (Pogue Depo., App. 346a; McDonald Aff., App. 49a)

Upon receipt of the order authorizing use of the policy, Blue Shield sent a standard form letter to all licensed pharmacies in the State offering them the opportunity to enter into a Pharmacy Agreement. (McDonald Aff., App. 48a; Johnson Depo., App. 147a) The formula pursuant to which Blue Shield offered to reimburse the Participating Pharmacies (*i.e.*, the acquisition cost of the drug, plus the $2.00 dispensing fee, minus the deductible) was determined in accordance with the collective bargaining agreement between the U.A.W. and the automobile manufacturers. (App. 211a-212a) There were no negotiations with or among the pharmacies. (App. 95a-96a, 98a-99a) Thereafter, Blue Shield issued the policy

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visions of Article 3.42. (App. 320a-322a, 324a-325a) Mr. McAnelly was head of the unit which had specific authority for approval of accident and health insurance policies. (App. 410a)] An exemption is therefore equivalent to an approval (Pogue Depo., App. 333a-334a; McAnelly Depo., App. 417a), and exempts the policy from nothing more than the requirement of formal approval by the State Board. (McAnelly Depo., App. 415a) Like approved policies, exempt policies are subject to all requirements of the Texas Insurance Code and to all aspects of the State Board's continuing regulation, control and supervision. (Connor Depo., App. 394a-395a; Pogue Depo., App. 332a-333a; McAnelly Depo., App. 416a, 419a) Indeed, "the degree of regulation may be a little greater with the exempt policy . . . ." (Connor Depo., App. 395a)

to various groups (McDonald Aff., App. 48a) and, in order to be able to provide the policy benefits, entered into the Pharmacy Agreement with pharmacies throughout Texas.

In 1974, Blue Shield decided to offer a comprehensive medical care plan, including prepaid prescription drug coverage, to various groups in the San Antonio metropolitan area. (McDonald Aff., App. 48a) In September, 1974, pursuant to Article 3.42 of the Insurance Code, a policy form identical to the one submitted in 1969 was filed with the State Board for approval prior to issuance. (App. 76a-77a; McDonald Aff., App. 49a) In October, 1974, the Commissioner issued an order approving use of the policy. (App. 385a-386a) After receipt of that approval order, Blue Shield issued the policy to various groups and, through another mass mailing, again offered the opportunity of entering into a Pharmacy Agreement to all licensed pharmacies in San Antonio. (McDonald Aff., App. 49a; App. 194a-195a)

C. The Complaint and the Decisions Below

Respondents brought suit in May, 1975 (App. 1a), alleging that the Pharmacy Agreements between Blue Shield and the pharmacy petitioners constituted a conspiracy to fix retail drug prices and to cause Blue Shield's insureds to refuse to deal with non-participating pharmacies in violation of § 1 of the Sherman Act, 15 U.S.C. § 1 (Supp. 1975). (App. 7a-8a) Respondents admitted in their complaint that in selling prepaid prescription drug insurance Blue Shield was engaged in the "business of insurance." (App. 7a) They contended, however, that in contracting with pharmacies to provide policy benefits to its insureds, Blue Shield was not engaged in the "business of insurance" within the meaning of the McCarran Act. (App. 106a) The proceedings in the District Court

focused on petitioners' defense that the McCarran Act barred the relief sought.

Upon the conclusion of extensive discovery regarding the "business of insurance" and other McCarran Act issues (App. 101a-102a), all parties agreed to submit the exemption defense for determination by the court. (App. 34a-37a) The District Court subsequently ordered suspension of all further discovery in order that the appropriate motions might be filed. (App. 38a-41a)

Petitioners' motions to dismiss for failure to state a claim were granted on the ground that both the policies and the Pharmacy Agreement were immunized from the Sherman Act by the McCarran Act.[9] Relying upon this Court's decision in *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453 (1969), the District Court determined that the policies and the Pharmacy Agreement were part of the "business of insurance", were regulated by Texas law under both the Texas Insurance Code and the State's antitrust statutes, and did not constitute a "boycott" within the meaning of the McCarran Act.

In deciding whether the Pharmacy Agreement was within the scope of the "business of insurance," the court found that the Agreement was based upon the coverage and benefits provisions of the policies; was simply the performance of Blue Shield's obligations owed to its insureds; and thus directly concerned the interpretation

[9] Each petitioner had separately moved to dismiss the complaint pursuant to Rule 12(b)(6), Fed. R. Civ. P., or for summary judgment under Rule 56. (App. 42a-44a, 81a-83a, 84a-85a, 86a-88a) The Court treated the motions as requests for summary judgment. (App. 115a) The applicability of the McCarran Act exemption was the only issue presented to and decided by the District Court. (App. 42a-44a, 81a-83a, 84a-85a, 86a-88a, 101a) Upon its dismissal of respondents' Sherman Act claims, the court also dismissed pendent claims, filed under the Texas antitrust laws, for lack of subject matter jurisdiction. (App. 114a)

and enforcement of the policies. (App. 107a) For these reasons, the District Court concluded that "the method adopted by Blue Shield of providing benefits under the [p]olicies is closely connected to the relationship between Blue Shield and its insureds." (App. 107a) Finally, the District Court held that by virtue of their contractual agreements with Blue Shield, the pharmacy petitioners had become "an integral part of the overall scheme of insurance coverage which is regulated by state law." (App. 113a) Consequently, the court found that to this extent they were engaged in the "business of insurance" and were also entitled to the protection afforded by the Act.

The Court of Appeals reversed, holding that the Pharmacy Agreement did not pertain to the relationship between Blue Shield and its insureds. Rejecting the District Court's factual findings that the Pharmacy Agreement was inseparable from the policy provisions relating to benefits and coverage, the court concluded that "Blue Shield's policyholders are basically unconcerned with the contract between the insurer and the Participating Pharmacy." [10] (App. 126a) As a result, the Court of Appeals held that the Pharmacy Agreement did not constitute the "business of insurance" for McCarran Act purposes.[11]

[10] The Court of Appeals repeatedly characterized Blue Shield's prescription drug policies and Pharmacy Agreements as "price-fixing" despite the fact that no evidence had been presented in the lower court or even any discovery undertaken on that issue. (App. 126a, 127a, 132a, 138a) Since the summary judgment did not reach the issue of price-fixing, the Court of Appeals exceeded its authority in purporting to address that issue. Fountain v. Filson, 336 U.S. 681 (1949). Were this Court to affirm the court below on the "business of insurance" issue, the case should be remanded to the District Court for discovery and trial on the merits of respondents' antitrust claims.

[11] Because its decision on the "business of insurance" issue was dispositive, the Court of Appeals found it unnecessary to reach the state regulation and boycott questions which the District Court had decided adversely to respondents. (App. 108a-112a)

SUMMARY OF ARGUMENT

The McCarran Act was designed to entrust regulation of insurance exclusively to the states by exempting the "business of insurance" from the Sherman, Clayton and Federal Trade Commission Acts to the extent that such business and any "person engaged therein" are "regulated by State law" and have not engaged in any act or agreement of "boycott, coercion and intimidation." 15 U.S.C. §§ 1011-1013 (1976). This immunity from federal antitrust scrutiny embraces the conduct challenged by respondents.

Drawing from the intent of the authors of the Act and from prior decisions, this Court in *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969), defined the "business of insurance" as centering upon "the relationship between insurer and insured." Specifically, (1) "the type of policy which could be issued," (2) "its reliability, interpretation and enforcement," and (3) "other activities of insurance companies [which] relate . . . closely to their status as reliable insurers" were described as the "core" of the business which Congress intended to withdraw from federal regulation. *Id.* Under each of these alternative criteria, Blue Shield's prescription drug insurance policies and the Pharmacy Agreement qualify as the "business of insurance."

The prepaid prescription drug insurance sold by Blue Shield protects against the risk that the insured might require drugs as prescribed by his doctor. In consideration of the premium, Blue Shield agrees to contract with Participating Pharmacies to furnish drugs to its insureds and to reimburse the pharmacies on behalf of the insureds for each prescription filled. The risk assumed by Blue Shield is therefore in the form of a contractual obligation to make payments to Participating Pharmacies

in the amounts and on the terms specified in the policy and Pharmacy Agreement. The policies and the Pharmacy Agreement thus display the "earmark" of insurance—the "underwriting of risks" in exchange for a premium. *Securities and Exchange Commission* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65, 73 (1959).

Insuring the policyholder against health care risks by providing him with a source of health care goods and services, rather than by reimbursing him in cash, is a traditional feature of Blue Shield and other health insurance plans. It is a form of insurance of which Congress was aware when it passed the McCarran Act. A major objective of insurance plans utilizing health care provider agreements is to reduce premiums by containing the costs of claims payments and by reducing administrative expenses. By contracting in advance with the provider, the insurer is able to predict more accurately the amounts which will have to be paid in satisfaction of claims and to limit escalation in claims costs during the term of the policy. The provider agreements also facilitate computer processing of claims, thereby decreasing administrative costs. As a result, the insurer is able to offer lower premium rates and a higher level of coverage. Because of these advantages, Blue Shield has chosen to extend this form of health insurance to cover prescription drugs in a manner similar to coverage of physicians' and hospitals' services.

The Pharmacy Agreement is the means by which the benefits provisions of the policy are implemented. Because Blue Shield has agreed to furnish policy benefits to its insureds through providers of prescription drugs, the only way such benefits can be guaranteed is through contractual arrangements with pharmacies. The failure to provide Participating Pharmacies which permit the insured to obtain drugs on the terms and for the amounts stated in the policies would constitute a breach of the

contract of insurance. The reliability of Blue Shield's drug policies is, as a consequence, substantially dependent upon its entering into Pharmacy Agreements for the benefit of its insureds.

The Pharmacy Agreement is also the means by which policyholder claims are satisfied. Blue Shield's chosen method of claims settlement, *viz.*, contracting with pharmacies to provide drugs under a specified reimbursement formula, was designed to slow the rate of increase in claims payments and to provide the insured with fuller compensation for his or her losses. Blue Shield's choice of the manner in which policy benefits are to be provided and the amounts to be paid on behalf of the insured is central to the enforcement of the insurance contract and, therefore, central to the policyholder-insurer relationship.

Finally, the rates charged by Blue Shield for its drug policies are determined primarily by the costs of drugs provided to its policyholders. The contractual arrangements between Blue Shield and Participating Pharmacies governing the amount of reimbursement for drugs therefore have a substantial impact not only on the prices charged by Blue Shield to its policyholders but also on its status as a solvent and reliable insurer.

Because it has a direct impact upon the type, interpretation, enforcement and reliability of the policy, the Pharmacy Agreement is thus part of the "business of insurance." Every other lower court decision in point has so interpreted and applied the standards established in *National Securities*, a fact conceded by the Court of Appeals below. (App. 135a-136a)

Consistent with this uniform application of the *National Securities* criteria, Texas considers an insurer to be engaging in the "business of insurance" when "furnishing the prescription service required by its service

agreement and pharmacy contracts." (App. 482a) Indeed, the very policies and the Pharmacy Agreement here in issue were necessarily considered by the State to be the "business of insurance" when it subjected them to the regulatory requirements of the Texas Insurance Code and authorized their use in the State. This form of administrative regulation, conducted pursuant to statutes specifically enacted in response to the McCarran Act, is the type of regulation to which Congress intended federal deference.

Because the Pharmacy Agreement is thus part of the "business of insurance," the pharmacy petitioners were engaged in that "business" when they executed and implemented the Agreement. Failure to extend the McCarran Act's immunity to both parties to the provider agreement would, contrary to the intent of Congress and the *National Securities* decision, restrict the exemption to the "business of insurance *companies*" rather than to the "business of *insurance*."

Reversal of the decision below is necessary not only because the Court of Appeals misapplies *National Securities*, but also because it subverts the purpose of the McCarran Act. The central objective of the Act was to renounce federal jurisdiction where it might result in nullifying or restricting state regulation of the insurer-insured relationship. By preventing or deterring insurers from guaranteeing "the provision of services on a simple 'cost-plus' basis or any other basis which might be more economical than the retail purchase of [prescription drugs]" (App. 129a), the Court of Appeals undermines this basic policy of the Act and, indeed, strikes at the heart of state regulation of health insurance. State insurance commissioners, acting in the interest of the insurance consuming public, would effectively be deprived of the ability to maintain health insurance rates at reasonable levels through encouragement and approval of cost containment measures such as provider agreements.

Because Blue Shield's Pharmacy Agreements are functionally inseparable from a "type of policy" which has long been a part of the business of health insurance, and because the Agreements directly relate to the "interpretation, reliability and enforcement" of the policy, the judgment of the Court of Appeals below should be reversed.

ARGUMENT

I. THE "BUSINESS OF INSURANCE" INCLUDES A CONTRACT BETWEEN AN INSURER AND A HEALTH CARE PROVIDER TO FURNISH BENEFITS OWED TO POLICYHOLDERS UNDER THE INSURER'S HEALTH CARE POLICIES

A. Introduction

In 1869, this Court held that insurance transactions were not interstate commerce within the meaning of the commerce clause and, therefore, were not subject to regulation by Congress. *Paul* v. *Virginia*, 75 U.S. (8 Wall.) 168 (1869). Seventy-five years later, however, in *United States* v. *South-Eastern Underwriters Association*, 322 U.S. 533 (1944), the Court determined that the insurance business is part of interstate commerce and is fully subject to the federal antitrust laws.

Congress promptly responded to the *South-Eastern Underwriters* decision by passing the McCarran Act.[12] It is the basic policy of the Act that "the continued regulation and taxation by the several States of the business of insurance is in the public interest . . . ." 15 U.S.C. § 1011 (1976). (Add. 1a) The "business of insurance" and "every person engaged therein" are therefore to be governed by "the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. 1012(a) (1976). (Add. 1a)

[12] As noted in SEC v. National Securities, Inc., 393 U.S. 453, 458 (1969), "[t]he McCarran-Ferguson Act was the product of [Congress'] concern" about "the inroads the [*South-Eastern Underwriters*] decision might make on the tradition of state regulation of insurance."

Under the Act, the federal government is removed from the field of insurance regulation in two distinct ways. First, with respect to federal legislation generally, the Act declares that "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance." 15 U.S.C. § 1012(b) (1976). (Add. 1a) Second, the Act expressly exempts the "business of insurance" from the Sherman Act, the Clayton Act and the Federal Trade Commission Act "to the extent that such business is . . . regulated by State law," 15 U.S.C. § 1012(b) (1976) (Add. 1a), except that the Sherman Act remains applicable to "boycott, coercion, or intimidation." 15 U.S.C. § 1013(b) (1976). (Add. 2a)

Among the federal statutes regulating competition, the McCarran Act is unique. It represents the single instance where Congress, although having the power to regulate competition in or affecting interstate commerce, has explicitly renounced the exercise of such power in deference to state regulation.[13] The area reserved to the states is not dependent upon the importance of the state's interests vis-a-vis federal interests, or upon the potential inconsistency of the state's regulatory scheme with the federal antitrust laws, but rather only upon the state's decision to occupy the field.[14]

[13] As one of the few express exemptions from the Sherman Act, the McCarran Act was enacted by Congress to accommodate "the special characteristics of a particular industry." National Soc'y of Professional Engineers v. United States, No. 76-1787 (decided April 25, 1978), Slip Op. at 9, 10 n.24.

[14] The McCarran exemption is thus far broader than the implied antitrust exemption established in Parker v. Brown, 317 U.S. 341

In its first decision applying the Act, this Court held that "Congress' purpose was broadly to give support to existing and future state systems for regulating and taxing the business of insurance" and "to throw the whole weight of [the Congress'] power behind the state systems," notwithstanding the fact that "they differ greatly in [their] scope and character" from state to state.[15] *Prudential Insurance Co.* v. *Benjamin*, 328 U.S. 408, 429-430 (1946).

Antitrust immunity exists under the McCarran Act for all conduct which constitutes part of the "business

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(1941), and subsequent cases, the latest of which is City of Lafayette v. Louisiana Power and Light Co., No. 76-864 (decided March 29, 1978). Indeed, Congress was specifically aware of the *Parker* case in considering passage of the McCarran Act, and expressly declined to limit the exemption to the narrow scope of the *Parker* decision:

> The Department of Justice also urged that the recent case of *Parker* v. *Brown* (317 U.S. 341), precludes the necessity of enacting the bill in order to preserve State regulation. *Parker* v. *Brown* dealt with a State commission authorized by State statute to enforce a program in conformity with, if not supplementary to, a Federal statute. Obviously, all State regulation concerning insurance does not and would not fall in such a category. [S. Rep. No. 1112, 78th Cong., 2nd Sess., at 5 (1944)]

See also H.R. Rep. No. 873, 78th Cong., 1st Sess., at 7 (1943); Cantor v. Detroit Edison Co., 428 U.S. 579, 608 n.4 (1976) (concurring opinion of Mr. Justice Blackmun). The House rejected an amendment to an early version of the McCarran Act which would have limited the exemption to acts specifically "required or authorized by State laws which affect or restrain interstate commerce . . . ." 78 Cong. Rec. 6563-64 (1944).

[15] The Act was intended to mandate federal deference to new or subsequent forms of state regulation, as well as to those forms of regulation existing in 1945. An important purpose of the Act was "to assure a more adequate regulation of [the insurance] business in the States by suspending the application of the Sherman and Clayton Acts for approximately two sessions of the State legislatures, so that the States and the Congress may consider legislation during that period." H.R. Rep. No. 143, 79th Cong., 1st Sess., at 3 (1945) (accompanying S. 340, which, as amended, became the Act). *See also* n.17, *infra*.

of insurance" and is "regulated" by state law. While the legislative history of the Act is replete with references to the state regulation requirement, there is little discussion of the scope of the term "business of insurance." In the course of passage of the Act, Congress did, however, demonstrate its intent that the term be broadly construed by declining to limit the exemption to specifically identified insurance industry practices and agreements.[16]

In *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453 (1969), this Court found that the term "business of insurance" must be construed in the light of the Act's purpose and history. The Court held that that term includes the fixing of rates, the selling and advertising of policies and the licensing of companies and their agents. 393 U.S. at 460. Further, the Court gave effect to the broad purpose of the Act by holding that the "business of insurance" extends to all insurance practices which involve "[t]he relationship between insurer and insured," including:

> the type of policy which could be issued, [or]
>
> its reliability, interpretation, and enforcement . . ., [or]
>
> other activities of insurance companies [which] relate . . . closely to their status as reliable insurers. . . . [*Id.*]

These factors were recognized to comprise the very "core of the 'business of insurance'" (*id.*), *and the presence of any one of them* would be sufficient to classify a practice as part of that "business."

Consistent with the legislative intent that the "business of insurance" not be defined by any mechanical test, *National Securities* left the definition of the term sufficiently flexible to serve the changing needs of the in-

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[16] *See* 79 Cong. Rec. 1444 (1945) (remarks of Senator O'Mahoney).

dustry.[17] Accordingly, the application of the *National Securities* criteria requires a pragmatic analysis of the particular conduct involved, focusing on its impact upon the insurer-policyholder relationship. Under each of the *National Securities* standards for measuring this impact —the type of policy, its interpretation and enforcement and the insurer's reliability—Blue Shield's policies and Pharmacy Agreements directly and materially affect that relationship.

B. "The Type of Policy": Prepaid Health Insurance Implemented Through Provider Agreements Is an Established Part of the "Business of Insurance"

In *Securities and Exchange Commission* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65, 73 (1959), the "earmark" of insurance was described as the "underwriting of risks" in exchange for a premium. Here the risk insured against is the possibility that, during the term of the policy, the insured may suffer a financial loss arising from the purchase of prescription drugs, or that he may be financially unable to purchase such drugs. In consideration of the premium, Blue Shield assumes this risk by agreeing with its insureds to contract with Participating Pharmacies to furnish the needed drugs and to reimburse the Pharmacies for each prescription filled for the insured. In short, each of the fundamental elements of insurance is present here—the payment of a premium in exchange for a promise to indemnify the insured against losses upon the happening of a specified contingency.

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[17] *See also* SEC v. Variable Annuity Life Ins. Co., 359 U.S. 65, 71 (1959):

> We realize that . . . insurance is an evolving institution. Common knowledge tells us that the forms have greatly changed even in a generation. And we would not undertake to freeze the concepts of "insurance" . . . into the molds [it] fitted when [the McCarran Act was] passed.

The prescription drug insurance program at issue is an example of prepaid health insurance generally. While this form of prescription drug insurance is a relatively recent development, the use of health care providers to furnish benefits owed to policyholders is a traditional feature of Blue Shield and Blue Cross health insurance plans. This method of insuring against health care risks has been described by one court as follows:

> In its contracts with subscribers [Blue Cross] agrees to furnish them needed health care services in return for premiums paid by them, or on their behalf (e.g., by employers). In order to carry out these obligations Blue Cross contracts with eligible hospitals. In a typical situation, a subscriber goes to a member hospital, presents his or her Blue Cross card, and receives health care services and the hospital sends the bill directly to Blue Cross. On the other hand, a patient insured under a traditional, private health insurance policy is billed for the services he receives and is entitled to receive cash indemnification by his insurer in an amount determined by his particular policy.
>
> Some of Blue Cross' subscriber agreements include indemnification provisions together with service benefit provisions. The indemnity clause comes into play when a subscriber receives care from a non-member hospital. Under most plans, Blue Cross' obligation is a relatively small fraction of the total charge for the service. For example, a subscriber may collect fifty dollars for the first day of hospitalization and twenty-five dollars for each subsequent day while the hospital's charge exceeds two hundred dollars per day. Blue Cross' role as an indemnity insurer of health care bills is relatively modest, compared to its service benefits business. [*Frankford Hospital* v. *Blue Cross of Greater Philadelphia*, 417 F. Supp. 1104, 1106 (E.D.Pa. 1976), *aff'd*, 554 F.2d 1253 (3d Cir.), *cert. denied*, —— U.S. ——, 98 S. Ct. 186 (1977)]

Prepaid prescription drug policies are merely an extension of this form of insurance to cover a different health care risk.

Texas Blue Shield was established in 1939 (App. 291a) and has been contracting directly with providers for the benefit of its insureds since that time. As the Attorney General of Texas has noted, "group health or group medical plans" with provider agreements of the type offered by Blue Shield "came into vogue during the depression." (App. 478a) Indeed, at the time of passage of the McCarran Act, Congress was aware of the use in the health insurance business of third-party provider agreements similar to those in issue here. Attorney General Biddle, in testimony during joint Congressional committee hearings on early versions of the McCarran Act, revealed that he had authorized the Government to bring the *South-Eastern Underwriters* case because of his belief that the Supreme Court, in *American Medical Association* v. *United States*, 317 U.S. 519 (1943), had held that prepaid health care plans were the business of insurance and were subject to the antitrust laws. The *AMA* case bears strong similarities to the instant case. It involved allegations that non-participating providers—physicians—had attempted to boycott a group health service ("Group Health") providing "medical care and hospitalization on a risk-sharing prepayment basis." 317 U.S. at 526. Group Health insured its members against health care risks by employing "physicians on a full time salary basis" and by seeking "hospital facilities for the treatment of members . . . ." *Id.* In current terminology, Group Health had entered into agreements with "participating providers." The Attorney General characterized this arrangement as the "business of insurance":

> [The *American Medical Association*] case involved a conspiracy against Group Health, in its essence indistinguishable from insurance although not formally so termed.
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> * * * *
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> [The Supreme Court's] definition [of Group Health's business] fits but one word, and that perfectly. The word is "insurance." [*Joint Hearing Before the Subcommittees of the Committees on the Judiciary on S. 1362, H.R. 3269 and H.R. 3270*, 78th Cong., 1st Sess., at 41 (1944)]

Blue Shield's prescription drug insurance program represents one response to the rapid escalation in the costs of health care services and to the urgings of government officials, employers and labor unions to provide health care delivery systems within the financial reach of the general public. A chief advantage of the Blue Shield plan is its cost savings to the policyholder. Unlike life insurance and some forms of property and casualty insurance, where the maximum dollar amount of the insuance companies' liability to the beneficiary is stated in the policy, prescription drug insurance involves an indeterminate liability. Because illnesses vary in frequency, duration and severity, and because the prices of prescription drugs are subject to rapid inflation, no one knows in advance of the insured's illness what monetary obligation Blue Shield will be required to bear to satisfy his or her claim. By contracting in advance with pharmacies to provide drugs under a specific reimbursement formula, Blue Shield is able to contain costs and predict more accurately the amounts it will be required to pay in satisfaction of its contractual obligations to its insureds. It is also protected, during the term of the policy and Pharmacy Agreement, against inflation in the retail mark-up on the acquisition costs of prescription drugs. Finally, it is able to reduce the administrative costs of processing claims by having the Participating Pharmacy file claims data on a composite rather than individual claims basis, using forms permitting direct

input into Blue Shield's computers. Because of these factors, Blue Shield is able to offer comparatively lower premium rates than those for health insurance policies where its liability is open-ended.

It is also able to provide a higher level of coverage for its policyholders. By virtue of the cost containment and claims predictability effects of the Pharmacy Agreement, Blue Shield is able to insure the policyholder for all but $2.00 of the drug purchase price. Conversely, because pharmacy prices are significantly less predictable and subject to unlimited escalation in the absence of the Pharmacy Agreement, Blue Shield can insure against only 75 percent of the risk borne by the insured in purchasing drugs from a non-participating pharmacy. Indeed, because a non-participating pharmacy may charge *more* than the "usual and customary" price upon which cash reimbursement to the insured is based, the insured may recover even less of his or her outlay.

In the exercise of its business judgment as an insurer, Blue Shield has thus decided to issue policies providing for goods and services benefits rather than offering cash indemnification exclusively. While Blue Shield could have decided otherwise, it is the very choice of "the type of policy which could be issued" which is itself the "business of insurance." Blue Shield's objective in electing to use a participating provider plan—the containment of claims costs—is also central to the "business of insurance."

The usefulness of prepaid provider plans in reducing health care costs and policyholder premiums has been consistently recognized by federal and state governments. The Council on Wage and Price Stability, for example, has determined that prepaid drug plans of the type in issue here "can reduce retail drug prices an estimated

15% or more." [18] The concern of state insurance commissioners over accelerating health care costs, and the exercise of their regulatory powers over prepaid health plans to contain such costs, have been documented in other litigation.[19] Virtually all states regulate such plans under their insurance codes, including special legislation designed to further the states' cost containment objective.[20]

The widespread use of group prepaid provider plans by commercial health insurers and health maintenance organizations,[21] as well as by Blue Shield and Blue Cross, is evidence of their importance to the business of health insurance. In addition to covering prescription drugs and physician and hospital services (App. 46a), many provider plans now cover dental, optometric and audiological goods and services. Prepaid health insurance has increasingly been among the fringe benefits negotiated in labor-management collective bargaining agreements.[22]

The decision below stands alone in its unrealistic attempt to separate the health care provider agreement

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[18] *Council on Wage and Price Stability*, EMPLOYEE HEALTH CARE BENEFITS: LABOR-MANAGEMENT INNOVATIONS IN CONTROLLING COSTS, 41 Fed. Reg. 40305 (1976).

[19] *See, e.g.*, Travelers Ins. Co. v. Blue Cross of Western Pennsylvania, 481 F.2d 80, 83-84 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973); Frankford Hospital v. Blue Cross of Greater Philadelphia, 417 F.Supp. 1104, 1106-07 (E.D. Pa. 1976), *aff'd*, 554 F.2d 1253 (3d Cir.), *cert. denied*, —— U.S. ——, 98 S. Ct. 186 (1977); Doctors, Inc. v. Blue Cross of Greater Philadelphia, 431 F.Supp. 5, 6-7, 10 (E.D. Pa. 1975), *aff'd*, 557 F.2d 1001 (3d Cir. 1977).

[20] A full discussion of state regulation is contained in the brief of the National Association of Insurance Commissioners ("NAIC") as *amicus curiae*.

[21] *See* discussion in *amicus curiae* brief of NAIC.

[22] In addition to the U.A.W. drug program, the Council on Wage and Price Stability notes that both the United Federation of Teachers (New York City) and the International Ladies' Garment Workers Union have adopted similar plans. *Op. cit.*, n.18.

from the underlying contract of insurance. In applying the *National Securities* criteria, all other courts have uniformly held that participating agreements between physicians and a health care insurer, *Anderson* v. *Medical Service of District of Columbia*, 551 F.2d 304 (4th Cir. 1977), *aff'g* 1976-1 CCH Trade Cas. ¶ 60,884 (E.D. Va. 1976); participating agreements between hospitals and insurers, *Travelers* v. *Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973); *Frankford Hospital* v. *Blue Cross of Greater Philadelphia*, 554 F.2d 1253 (3d Cir.), *cert. denied*, —— U.S. ——, 98 S. Ct. 186 (1977); *Doctors, Inc.* v. *Blue Cross of Greater Philadelphia*, 557 F.2d 1001 (3d Cir. 1977), *aff'g* 431 F. Supp. 5 (E.D. Pa. 1975);[23] and participating agreements between dentists and insurers, *Manasen* v. *California Dental Services*, 424 F. Supp. 657 (N.D. Cal. 1976), *appeal pending*, Nos. 77-1751 and 77-

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[23] The court below sought to distinguish the *Travelers* and *Doctors, Inc.* cases on the ground that the state insurance commissioner had regulated hospital reimbursement rates and had urged insurers to contain such rates in order to maintain premiums at reasonable levels. (App. 130a) The court, however, has confused the "state regulation" and "business of insurance" requirements of the McCarran Act. Whether or not provider agreements are regulated by the state, they are part of the "business of insurance" if they meet the *National Securities* criteria, as they were found to do in *Travelers* and *Doctors, Inc.* Moreover, as discussed *infra*, at 31-35, the court's factual premise is mistaken; Texas has exercised its regulatory powers over Blue Shield's Pharmacy Agreements.

The court below also relied heavily on Battle v. Liberty Nat. Life Ins. Co., 493 F.2d 39 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110 (1975), for the proposition that provider agreements are not necessary appendages of the insurance contract. (App. 131a-132a) As the District of Columbia Court of Appeals has recognized, however, *Battle* is inapposite where there is a *direct* contract between the insurer and the provider of services, and where the services provided are *required* by the policy of insurance. *See* Proctor v. State Farm Mut. Auto. Ins. Co., *supra*, 561 F.2d at 270; *see also* Frankford Hospital v. Blue Cross of Greater Philadelphia, 417 F.Supp. 1104, 1110-11 (E.D. Pa. 1976).

1752 (9th Cir.), are an integral part of the "business of insurance."[24] The common feature of these cases has been the use of provider agreements by the insurer to furnish a source of health care services or goods to the insured in lieu of cash indemnification. The provider agreements in all of these cases incorporated reimbursement formulas establishing ceilings or other restrictions on the costs which would be recompensed, thus containing the costs of claims and reducing premiums. In addition, in each case the insurance policy provided a lower percentage level of benefits or lesser coverage to the insured if he or she patronized non-participating providers, because the cost containment provisions of the provider agreement were not applicable. Every court faced with this form of prepaid health insurance—save for the court below—has found that the direct and substantial impact on rates, the very nature of the type of policy issued, and the insurer's obligation to provide services to its insureds together bring policies and provider agreements such as these well within the "business of insurance."

C. The Policy's "Reliability and Enforcement": Blue Shield's Pharmacy Agreements Are Indispensable to the Furnishing of Policy Benefits and Settling of Claims

The reliability of Blue Shield's policies is principally dependent upon Blue Shield's contracting with Participating Pharmacies for the benefit of its insureds. The benefits section of Blue Shield's drug policy provides that the insureds (1) "shall be entitled to receive covered drugs from any participating provider as a benefit here-

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[24] *See also* Nankin Hospital v. Michigan Hospital Serv. 361 F. Supp. 1199 (E.D. Mich. 1973) (participating agreements between hospitals and insurer); St. Bernard General Hospital v. Hospital Service Ass'n of New Orleans, Inc., 1978-1 CCH Trade Cas. ¶ 61,868 (E.D. La. 1977) (same); Winters v. Kansas Hospital Service Ass'n, Inc., 1975-1 CCH Trade Cas. ¶ 60,140 (D. Kan. 1974) (same).

under" and (2) "shall be required to pay no more than the drug deductible for each of such covered drugs." (App. 55a) In satisfaction of this dual obligation to insureds, the Pharmacy Agreement first serves to provide a guaranteed source of goods and services.

Second, after the insured's loss has arisen, the Pharmacy Agreement serves as the mechanism through which the claims of Blue Shield's insureds are settled. The Pharmacy Agreement thus implements "the insurance company's agreement, in return for a premium, to make payments to or on behalf of the policyholder for losses arising out of" the risks covered by the insurance contract. *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, 561 F.2d 262, 267 (D.C. Cir. 1977), *pet. for cert. pending*, No. 77-580. The process of determining the manner in which claims payments will be made and the amount to be paid on behalf of or to insureds is certainly peculiar to the "business of insurance." [25] It is nothing less than the "discharge of [the] contractual obligation . . . at the heart of the relationship between insurer and insured, and is directly connected with the reliability, interpretation, and enforcement of the insurance contract." *Id.* By dealing directly with the provider of goods and services to the insured, the insurer hopes to "slow the rate of increase in the claims payments required to satisfy [its] contractual obligation to [its] policyholders." *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, *supra*, 561 F.2d at 268. This goal is intimately connected to the insurer-insured relationship.

[25] In at least one instance during the legislative debates over passage of the McCarran Act, the "servicing of claims" was recognized to constitute the "business of insurance." 78 Cong. Rec. 6550 (1944) (remarks of Congressman Ploeser).

D. "Status as a Reliable Insurer": The Pharmacy Agreement Has a Direct Impact on Premium Levels and Thus on Blue Shield's Solvency and Reliability

A consistent line of decisions construing the McCarran Act has held that insurance company practices having a direct and substantial bearing upon rates are included within the "business of insurance" because (1) the price a policyholder pays for his coverage is a central aspect of the insurer-insured relationship, and (2) rate levels largely determine the solvency and reliability of the insurer. For example, in *Travelers Insurance Co.* v. *Blue Cross of Western Pennsylvania*, 481 F.2d 80, 83 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973), the Court of Appeals found Blue Cross' provider agreements with hospitals to be within the "business of insurance" because of the "interrelationship of hospital payments and subscribers' rates." [26] *See also Frankford Hospital* v. *Blue Cross of Greater Philadelphia*, 554 F.2d 1253 (3d Cir.), *cert. denied*, —— U.S. ——, 98 S. Ct. 186 (1977); *Doctors, Inc.* v. *Blue Cross of Greater Philadelphia*, 557 F.2d 1001 (3d Cir. 1977), *aff'g* 431 F. Supp. 5 (E.D. Pa. 1975); *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, *supra*, 561 F.2d at 268-69.

[26] The testimony of Pennsylvania Insurance Commissioner Herbert S. Denenberg in the *Travelers* case underscores the direct relationship between provider reimbursement rates and premium levels:

> Q. Commissioner, in carrying out the responsibilities of your office as you see them, what relation, if any, have you found to exist between a Blue Cross plan reimbursement contract with its hospitals and the Blue Cross plan subscriber rates?
>
> A. Well, these two things are really indivisible aspects reflecting the same economic forces. If you do not have a sound contract between Blue Cross and the hospitals that controls cost and quality then the Blue Cross rate to the subscribers is going to be unreasonable. [481 F.2d at 83, n.9.]

Since the cost of prescription drugs is the only risk covered by Blue Shield's drug policy, the premiums it charges are based largely upon the cost of drugs provided to its policyholders.[27] The primary objective of the contractual arrangements between Blue Shield and Participating Pharmacies is to contain these costs and make them more predictable for rate-making purposes, so as to enable an economical and efficient program of prescription drug insurance. The Pharmacy Agreement thus plays an essential role in Blue Shield's rate-making process. That process is at the core of the "business of insurance": "Certainly, the fixing of rates is part of this business; that is what *South-Eastern Underwriters* was all about." *Securities & Exchange Commission* v. *National Securities, Inc.*, *supra*, 393 U.S. at 460.

The Court of Appeals did not deny the existence of this close interrelationship of claims costs and rates, but nonetheless concluded that an impact upon rates was not, standing alone, enough to bring an activity within the "business of insurance." (App. 137a) It is no doubt true that not all cost reduction by insurers constitutes exempt conduct regardless of the substantiality of the effect on rates. The sufficiency of the impact on rates, however, is unquestionable where, as here, the insurer has acted to contain the cost of *claims* for the *sole* risk it has underwritten—the purchase price of prescription drugs. The interdependence of drug prices and policy rates is, moreover, not the only means by which the Pharmacy Agreement has a direct impact on the insurer-insured relationship. As already noted, the Agreement is functionally inseparable from the type of benefits provided in the

[27] The administrative and overhead costs of selling policies and processing claims is the other major determinant of rates. This element also is affected by Blue Shield's Pharmacy Agreements, which enable automated processing of claims and thus lower administrative costs. (Helis Depo., App. 283a-284a)

policy, the coverages specified and the manner of handling claims. In sum, the Pharmacy Agreement is at the core of the basic prepaid insurance undertaking.

E. Regulation of Blue Shield's Policies and Pharmacy Agreements Under the Texas Insurance Code Confirms That They Are the "Business of Insurance"

The pervasive regulation of Blue Shield's prescription drug policies and the Pharmacy Agreement by the Texas State Board of Insurance further demonstrates that Blue Shield's arrangements with pharmacies are part of the "business of insurance." [28]

The Attorney General of Texas has long considered that prescription drug insurance plans (including provider agreements) constitute the "business of insurance" in Texas. With regard to a prepaid prescription drug program identical in concept and operation to the Blue Shield plan, the Attorney General concluded that the insurer "would be engaging in the business of insurance, in furnishing the prescription service required by its service agreements and pharmacy contracts." (App. 482a; for description of plan, *see* App. 475a-477a.)

[28] It is, of course, true that the meaning of the "business of insurance" is a federal question. SEC v. Variable Annuity Life Ins. Co., 359 U.S. 65, 69 (1959). Nevertheless, in the McCarran Act "Congress was legislating concerning a concept which had taken on its coloration and meaning largely from state law, from state practice, from state usage." *Id.* It is noteworthy that the original draft of the McCarran Act was proposed by the National Association of Insurance Commissioners. *See* 79 Cong. Rec. 1488 (1945) (remarks of Senator Barkley). That draft incorporated the term "business of insurance" ultimately included in the final Act. Accordingly, the views of state regulators on what constitutes the "business of insurance", as evidenced by state regulatory enactments, are highly probative in construing the Act. Unlike the "annuity" contracts involved in *Variable Annuity*, however, there is here no lack of uniformity among the states on the nature of health care provider contracts. Virtually all states regulate such arrangements under their insurance codes, typically under special provisions governing non-profit insurers such as Blue Cross and Blue Shield. *See* discussion in *amicus curiae* brief of NAIC.

Texas' views on the nature of prepaid drug plans are even more strongly demonstrated by the State's actual regulation of the policies and Pharmacy Agreement in question. The former Deputy Commissioner of the State Board testified in this case that Blue Shield's drug policy and Pharmacy Agreement constitute the business of insurance, and are subject to the full regulation, control and supervision of the State Board. (Connor Depo., App. 394a-395a)

Regulation of health insurance policies in Texas assumes several forms. Article 3.42 of the Insurance Code, *Tex. Ins. Code Ann.* art. 3.42 (Supp. 1977), passed shortly after the McCarran Act, requires state approval prior to issuance of individual and group health insurance policies. (Add. 2a-4a; Pogue Depo., App. 326a-327a) Broad discretion is vested in the State Board to approve or disapprove proposed policies. (Pogue Depo., App. 326a; Connor Depo., App. 393a) Policies may be rejected for any failure to comply with the Insurance Code, or for any "provisions which encourage misrepresentation or are unjust, unfair, inequitable, misleading, deceptive or contrary to law or the public policy of the State." (Add. 4a; McAnelly Depo., App. 412a) Use of unapproved policies subjects the issuer to civil fines. (Pogue Depo., App. 331a)

In addition, Article 21.21 of the Texas Insurance Code, *Tex. Ins. Code Ann.* art. 21.21 (1963), was enacted in 1951 for the express purpose of regulating unfair competition and unfair practices in the business of insurance. (Add. 4a-14a) Article 21.21 was specifically intended by its draftsmen to respond to the invitation of the McCarran Act to withdraw from federal control the very conduct attacked by respondents in this action and to place such

conduct under state control.[29] All policies are examined by the State Board in light of the regulatory requirements of Article 21.21, as well as those of Article 3.42. (Pogue Depo., App. 335-336a; Connor Depo., App. 398a) The Board has extensive investigative powers under Article 21.21, and it may prohibit unlawful practices by cease and desist orders, violation of which will result in civil penalties. *Tex. Ins. Code Ann.* art. 21.21 §§ 5-7, 10 (1963). (Add. 7a-9a) Later amendments to the Act, *Tex. Ins. Code Ann.* art. 21.21 §§ 14-15 (Supp. 1977), authorize the Board (through the Attorney General) temporarily or permanently to enjoin unfair practices and to recover damages on behalf of insureds. (Add. 10a-12a) Policyholder individual and class actions are also permitted. *Tex. Ins. Code Ann.* art. 21.21 §§ 16-17 (Supp. 1977) (Add. 12a-14a) A related provision, Article 21.21-2, *Tex. Ins. Code Ann.* art. 21.21-2 (Supp. 1977), prohibits unfair practices in claims settlement. (Pogue Depo., App. 336a; Connor Depo., App. 399a)

Blue Shield's prescription drug policies and Pharmacy Agreements were reviewed by the State for compliance with these statutes. Indeed, in 1969, the State Board initially disapproved Blue Shield's prescription drug policy and the annexed Pharmacy Agreement because it believed the agreement might violate Article 21.21. The reason for initial disapproval—alleged discrimination between insureds who patronized participating pharmacies

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[29] Statutes like Article 21.21, which specifically prohibit unfair competition and unfair practices in the insurance business, constitute state regulation and thus trigger the McCarran Act exemption. *See, e.g.*, Dexter v. Equitable Life Assurance Soc'y, 527 F.2d 233, 236 (2d Cir. 1975); Crawford v. American Title Ins. Co., 518 F.2d 217, 219 (5th Cir. 1975). It was exactly this form of "prohibitory legislation" authorizing "enforcement through a scheme of administrative supervision" which was found to be sufficient state regulation within the meaning of the McCarran Act in FTC v. National Casualty Co., 357 U.S. 560, 564 (1958). The Court noted that, at the time the *National Casualty* complaints were filed, thirty-six states had enacted the "Model Unfair Trade Practices Bill for Insurance" drafted by the state commissioners. *Id.*, at 564, n.6. It was this bill that was passed as Article 21.21 of the Texas Code.

and those who patronized non-participants—was similar to respondents' present objections. (App. 365a-366a) Thereafter, the proposed insurance program remained under consideration by the State Board and the Commissioner subsequently authorized the program. (App. 370a-371a) The record demonstrates that the State Board could have, "almost as an injunction matter," prohibited the issuance of the policy and the concomitant use of the Pharmacy Agreement. (Connor Depo., App. 395a) The Board, however, determined not to do so:

> [I]t was almost as if we had a Motion in Limine to stop the doing of what they were proposing to do. We could have stopped it through the medium of refusing to approve and refusing to exempt the contract on which activity was being pursued, but as these Exhibits indicate, the departmental action was to refer the matter to the Attorney General and not to block the doing of what was being done through the device of refusing to allow a form to be used. [Connor Depo., App. 395a]

In 1974, when Blue Shield submitted an identical policy to the State Board (App. 374a-376a), it was promptly approved for issuance by order of the Commissioner.[30]

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[30] In addition to regulation under the Texas Insurance Code, anticompetitive practices in the "business of insurance" are prohibited by the Texas antitrust laws and are subject to civil and criminal penalties. *Tex. Bus. & Comm. Code Ann.* §§ 15.02, 15.04, 15.29, 15.32, 15.33 (1963). (Add. 14a-17a) Respondents' allegation that Blue Shield and the pharmacy petitioners conspired to fix the retail price of drugs through the use of the Pharmacy Agreement (App. 7a-8a) falls within the scope of these state statutes. Respondents so concede by including in their complaint a pendent claim under the Texas antitrust laws based upon the same facts that are alleged to give rise to a violation of the federal antitrust laws. (App. 10a) The policies and Pharmacy Agreements here in issue were referred by the State Board, after its review, to the Texas Attorney General for consideration under the state antitrust statutes. (App. 370a-371a) No action was ever commenced against petitioners. (McDonald Aff., App. 49a; Connor Depo., App. 396a) The existence of state antitrust laws proscribing the conduct complained of constitutes

In sum, Texas considers Blue Shield's policies and provider agreements to be the "business of insurance" and, as such, subject to the full panoply of state insurance regulation: the "prior approval" system which was the prevalent form of state regulation when Congress passed the McCarran Act;[31] the unfair practices legislation passed in response to the McCarran Act; and state antitrust legislation specifically directed at the "business of insurance."

II. BECAUSE THE PHARMACY AGREEMENTS CONSTITUTE THE "BUSINESS OF INSURANCE," THE PHARMACY PETITIONERS ARE ALSO PROTECTED BY THE McCARRAN ACT

In a terse footnote (App. 135a), the Court of Appeals apparently held that non-insurance companies, including the pharmacy petitioners, are automatically ineligible for the McCarran Act exemption. However, "[t]here is nothing in the McCarran Act which limits the 'business of insurance' to the business of insurance companies." *Lowe* v. *Aarco-American, Inc.*, 536 F.2d 1160, 1162 (7th Cir. 1976).[32] To the contrary, the protection afforded by the

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regulation within the meaning of the McCarran Act sufficient to displace the federal antitrust laws. *See, e.g.*, Meicler v. Aetna Cas. and Sur. Co., 506 F.2d 732, 734 (5th Cir. 1975).

Texas also regulates Blue Shield by means of its authority under Chapter 3 of the Code to grant or cancel licenses, require reports, compel maintenance of reserves and inspect financial condition and management practices. *See, e.g., Tex. Ins. Code Ann.* arts. 3.04, 3.06, 3.07, 3.28, 3.32, 3.35-3.36, 3.57 (1963 and Supp. 1977). (*See also* Bunnell Depo., App. 424-425a, 428a.) Violation of any provision of the Code subjects the insurer to possible loss of license or civil penalty. *Tex. Ins. Code Ann.* arts. 3.55, 3.70-9 (Supp. 1977).

[31] *See, e.g.*, 78 Cong. Rec. 6544 (1944) (remarks of Congressman Clason).

[32] A number of cases have determined that persons acting on behalf of insurers or insureds in the sale or enforcement of the

Act is expressly extended to the "*business* of insurance, *and every person engaged therein.*" 15 U.S.C. § 1012(a) (1976) (emphasis added). It is the nature of the conduct —in this case, the Pharmacy Agreement—which must be examined, not the identity of the parties.

In this respect, the McCarran exemption is analogous to the labor exemption from the antitrust laws. Since it is the collective bargaining *agreement* which is immune, the exemption is available to employers as well as unions. *See, e.g., Mackey* v. *National Football League*, 543 F.2d 606, 612 (8th Cir. 1976), *cert. dism'd* (September 12, 1977, No. 76-932); *Scooper Dooper, Inc.* v. *Kraftco Corp.*, 494 F.2d 840, 847 n.14 (3d Cir. 1974). Labor immunity thus applies to both unions and employers if the provisions of the collective bargaining agreement sufficiently relate to the conduct sought to be protected, *i.e.*, if they relate to proper subjects of collective bargaining. *See, e.g., Amalgamated Meat Cutters* v. *Jewel Tea Co.*, 381 U.S. 676 (1965).[33]

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contract of insurance are engaged in the "business of insurance." Insurance agents and brokers, SEC v. National Securities, Inc., *supra*, 393 U.S. at 460; U.S. v. New Orleans Ins., Exch., 148 F. Supp. 915 (E.D. La.), *aff'd per curiam*, 355 U.S. 22 (1957); Lowe v. Aarco-American Inc., *supra*, 536 F.2d at 1162; and premium finance companies, Lowe v. Aarco-American, Inc., *supra*, 536 F.2d at 1162; Cochran v. Paco, 409 F.Supp. 219, 222 (N.D. Ga. 1975), have been found to engage in that business. The role of Participating Pharmacies in settling claims and providing policy benefits is intrinsically no different. As the District Court found, the pharmacy petitioners are "an integral part of the overall scheme of insurance coverage which is regulated by state law." (App. 113a)

[33] The availability of other statutory antitrust exemptions is also to be assessed in terms of the conduct involved rather than the status of the parties. For example, in Hughes Tool Co. v. Trans World Airlines, Inc., 409 U.S. 363 (1973), this Court found that transactions between an air carrier, fully regulated by the Civil Aeronautics Board (CAB), and its owner, which was not CAB-licensed, were nonetheless exempt from the Sherman Act under § 414 of the Federal Aviation Act of 1958, 49 U.S.C. § 1384 (1970), because the *transactions* in question had been regulated by the

The McCarran Act is similarly conduct-oriented, for it applies to all activities having the requisite linkage to the insurer-insured relationship as defined in *National Securities*. Because it satisfies all of the criteria of *National Securities*, the Pharmacy *Agreement* constitutes the "business of insurance." *A fortiori*, the signatories to the contract are engaged in that business to the extent they execute and implement the contract.[34] Failure to extend the McCarran Act's immunity to the pharmacy petitioners therefore would be logically inconsistent with holding that the Agreement itself is exempt.

III. UNLESS REVERSED, THE DECISION OF THE COURT OF APPEALS WILL HAVE EXACTLY THE DISRUPTIVE EFFECT ON STATE INSURANCE REGULATION WHICH IT WAS THE PURPOSE OF THE McCARRAN ACT TO AVOID

The primary concern of the authors of the McCarran Act was avoiding the disruption of traditional state regulation that was thought likely to be caused by the *South-*

CAB. *See also* Scroggins v. Air Cargo, Inc., 534 F.2d 1124 (5th Cir. 1976), where the court found that a contract between CAB-regulated air carriers and a non-regulated trucker was immune under the Aviation Act because the contract had been approved by the Board.

[34] With the sole exception of the Court of Appeals below, every other court having occasion to review provider agreements has found that the *agreement* is part of the "business of insurance." *See* pp. 26-27, *supra*. Indeed, in one of those cases, Doctor's, Inc. v. Blue Cross of Greater Philadelphia, 557 F.2d 1001 (3d Cir. 1977), the Court of Appeals for the Third Circuit affirmed the lower court's dismissal (1977-2 CCH Trade Cas. ¶ 61,693 (E.D. Pa. 1975)) of the complaint as to a private health care and hospital advisory agency (as well as Blue Cross), even though the agency was not directly a party to Blue Cross' reimbursement contracts with hospitals. The agency had recommended to Blue Shield what hospital services should or should not be included in the provider agreement. The agency was dismissed as a defendant because "it is axiomatic that if Blue Cross has not violated the antitrust laws, [the agency] could not be guilty of conspiring with Blue Cross to violate those laws." 1977-2 CCH Trade Cas. at p. 72,481.

Eastern Underwriters decision.[35] Congress not only feared that state laws might be nullified, but also that a spate of litigation would ensue to determine which state statutes and regulations were preempted by the federal antitrust laws (and other statutes based on the commerce clause) and which were not.[36]

Each of these important legislative purposes would be vitiated or thwarted by the decision below. The potential for conflict between the Sherman Act and state insurance regulation is well demonstrated by the Court of Appeals' conclusion that "Blue Shield is not required to

[35] *See, e.g.*, 78 Cong. Rec. 6529-30 (1944) (remarks of Congressman Satterfield):

> The opinions of the minority in the South-eastern case should be listened to by the Congress with great respect. The admonition of Justice Stone must not go unheeded. The gravity of the situation is best described in the words of the Chief Justice when he said:
>
> > It's (the Supreme Court's) action in now overturning the precedents of 75 years governing a business of such volume and such wide ramification cannot fail to be the occasion for loosing a flood of litigation and of legislation, State and National, in order to establish a new boundary between State and National power, raising questions that cannot be answered for years to come, during which a great business and the regulatory officers of every state must be harassed by all the doubts and difficulties inseparable from a realignment of the distribution of power in our Federal system. These considerations might well stay reversal of established doctrine which promises so little advantage and so much harm. For me these considerations are controlling.

[36] *See, e.g.*, 78 Cong. Rec. 6549 (1944) (remarks of Congressman Michener). A related Congressional purpose was to prevent insurers from being placed in the dilemma of attempting to comply with conflicting state and federal regulatory strictures. *See, e.g.*, H.R. Rep. No. 143, 79th Cong., 1st Sess., at 2 (1945); H.R. Rep. No. 873, 78th Cong., 1st Sess., at 7 (1943); 78 Cong. Rec. 6454 (1944) (remarks of Congressman Vorys); 78 Cong. Rec. 6526 (1944) (remarks of Congressman Hancock); 78 Cong. Rec. 6527 (1944) (remarks of Congressman Miller); 78 Cong. Rec. 6556 (1944) (remarks of Congressman Graham).

guarantee the provision of services on a simple 'cost-plus' basis or any other basis which might be more economical than the retail purchase of [prescription drugs]." (App. 129a) Indeed, the court below would limit an insurer's means of "protect[ing] itself from rising costs" to "establish[ing] a periodically adjusted rate structure to reflect the impact of inflation." (App. 129a) Under this view, insurers could no longer employ any method, including the widely-used provider concept, of keeping health insurance premiums down by containing health care costs except at the risk of antitrust liability.

As this case so clearly demonstrates, removing health care provider agreements from the "business of insurance" will also effectively prevent the states from fostering the use of cost containment measures through the policy approval mechanism or otherwise. Notwithstanding that Texas has approved the use of prepaid drug policies utilizing Participating Pharmacies, the relief sought by respondents would preclude issuance of any policies except those granting reimbursement on the basis of the "usual and customary" drug price. Likewise, state regulation and maintenance of insurance company solvency would be hampered if insurers were prevented or deterred from containing claims costs through provider agreements.

In effect, the Court of Appeals has assumed a role properly reserved for the state insurance commissioner. It is the policy of the McCarran Act to allow the states freedom to determine—through their legislative and administrative processes—the best means of ensuring the availability of insurance at reasonable rates by insurers whose reliability is adequately safeguarded.[37] Congress

[37] A correlative purpose of the Act was to preserve state regulation because of the absence of any federal regulation specifically directed at the insurance industry. Quoting the dissents in *South-Eastern Underwriters*, the sponsors of the Act repeatedly noted

was aware that the federal antitrust laws' objective of unrestricted competition might conflict with these state regulatory goals,[38] and it granted priority to the latter.

The health insurance industry has long used provider agreements, the states have long exercised their regulatory authority over such agreements and the public has benefitted from the resulting lower rates. In these circumstances, this Court should reaffirm "the policy announced by Congress in the McCarran-Ferguson Act," a policy "on which the industry [has] had reason to rely." *State Board of Insurance* v. *Todd Shipyards Corp.*, 370 U.S. 451, 457 (1962). As this Court has noted in a similar context, failure to do so will permit the erosion of state insurance regulation through piecemeal litigation in the federal courts:

> The hearings on the McCarran Act reveal the complexities and difficulties of an attempt to unify insurance law on a nationwide basis, even by Congress. Courts would find such a task far more difficult.

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that the federal government, in contrast to the states, had "adopted no legislative policy and evolved no scheme of regulation with respect to the business of insurance." 78 Cong. Rec. 6541 (1944) (remarks of Congressman Fellows, quoting Chief Justice Stone's dissent). *See also* dissent of Mr. Justice Jackson, quoted *id.*

[38] Congress, for example, realized that rating bureaus, pooling arrangements, reinsurance treaties and other industry practices might not pass federal antitrust scrutiny but might nonetheless be considered by the states as necessary to preserve the reliability of insurers while also assuring reasonable rates. *See, e.g.*, H.R. Rep. No. 873, 78th Cong., 1st Sess., at 9 (1943); 78 Cong. Rec. 6527 (1944) (remarks of Congressman Miller). An express purpose of the Act was thus to grant the states the opportunity "to permit *agreements and contracts* by insurance companies which might otherwise be in violation of the Sherman and Clayton Acts." H.R. Rep. 143, at 3 (1945) (emphasis added); *see also* 79 Cong. Rec. 1443-4, 1486 (1945) (remarks of Senator McCarran). The Court of Appeals below ignored this aspect of the Act when it seemingly held that all anticompetitive conduct is not "peculiar" to the business of insurance and is thus ineligible for the exemption. (App. 137a-138a)

> Congress in passing laws is not limited to the narrow factual situation of a particular controversy as courts are in deciding lawsuits. And Congress could replace the presently functioning state regulations of . . . insurance by one comprehensive Act. Courts, however, could only do it piecemeal, on a case-by-case basis. Such a creeping approach would result in leaving . . . insurance largely unregulated for years to come. [*Wilburn Boat Co.* v. *Fireman's Fund Insurance Co.*, 348 U.S. 310, 319 (1955).]

In the words of Senator McCarran, the Act was "an invitation to the States to legislate in good faith." 79 Cong. Rec. 1487 (1945). Texas has done so through regulation specifically aimed at the relationship between insurer and insured. The Congressionally mandated policy of deference to this regulation can be effectuated only by construing the "business of insurance" to include a traditional and widely-used means of satisfying the insurer's obligations to its policyholders.

CONCLUSION

For the foregoing reasons, the judgment of the Court of Appeals for the Fifth Circuit should be reversed.

Respectfully submitted,

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ADDENDUM

ADDENDUM

RELEVANT PROVISIONS OF McCARRAN-FERGUSON ACT

McCarran Act § 1, 15 U.S.C. § 1011 (1976):

Declaration of Policy.

Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation of taxation of such business by the several States.

McCarran Act § 2, 15 U.S.C. § 1012 (1976):

Regulation by State Law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948.

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

McCarran Act § 3, 15 U.S.C. § 1013 (1976):

Suspension until June 30, 1948, of application of certain Federal laws; Sherman Anti-Trust Act applicable to agreements to, or acts, of boycott, coercion, or intimidation.

(a) Until June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, and the Act of June 19, 1936, known as the Robinson-Patman Anti-discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

RELEVANT PROVISIONS OF THE TEXAS INSURANCE CODE AND ANTITRUST LAWS

Tex. Ins. Code Ann. art. 3.42 (Supp. 1977):

Policy Form Approval

(a) No policy, contract or certificate of life, term or endowment insurance, group life or term insurance, industrial life insurance, accident or health insurance, group accident or health insurance, hospitalization insurance, group hospitalization insurance, medical or surgical insurance, group medical or surgical insurance, or fraternal benefit insurance, and no annuity or pure endowment contract of group annuity contract, shall be delivered, issued or used in this by a life, accident, health or casualty insurance company, a mutual life insurance company, mutual insurance company other than life,

mutual or natural premium life insurance company, general casualty company, Lloyds, reciprocal or inter-insurance exchange, fraternal benefit society, group hospitalization service or any other insurer, unless the form of said policy, contract or certificate has been filed with the state Board of Insurance and approved by said Board as provided in Paragraph (c) of this Article.

. . .

* * * *

(c) Every such filing hereby required shall be made not less than thirty days in advance of any such issuance, delivery or use. At the expiration of thirty days the form so filed shall be deemed approved by the State Board of Insurance unless prior thereto it has been affirmatively approved or disapproved by the written order of said Board. The State Board of Insurance may extend by not more than an additional thirty days the period within which it may so affirmatively approve or disapprove any such form, by giving notice of such extension before expiration of the initial fifteen day period and at the expiration of any such extended period, and in the absence of such prior affirmative approval or disapproval, any such form shall be deemed approved. The Board of Insurance Commissioners may withdraw any such approval at any time. Approval of any such form by such Board shall constitute a waiver of any unexpired portion of the waiting period, or periods, herein provided.

(d) The order of the State Board of Insurance disapproving any such form or withdrawing a previous approval shall state the grounds for such disapproval or withdrawal.

(e) The State Board of Insurance may, by written order, exempt from the requirements of this Article for so long as it deems proper, any insurance document or form specified in such order, to which in its opinion this

Article may not practicably be applied, or the filing and approval of which are, in its opinion, not desirable or necessary for the protection of the public.

(f) The State Board of Insurance shall forthwith disapprove any such form, or withdraw any previous approval thereto if, and only if,

(1) It is in any respect in violation of or does not comply with this Code.

(2) It contains provisions which encourage misrepresentation or are unjust, unfair, inequitable, misleading, or deceptive or contrary to law or to the public policy of this state.

(3) It has any title, heading or other indication of its provisions which is misleading.

* * * *

Tex. Ins. Code Ann. art. 21.21 (1963 and Supp. 1977):

Unfair Competition and Unfair Practices

Sec. 1. *Declaration of Purpose.*—The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1946 (Public Law 15, 79th Congress),[1] by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

Sec. 2. *Definitions.*—When used in this Act:

(a) "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds insurer, fraternal benefit society, and any

[1] 15 U.S.C.A. §§ 1011-1015.

other legal entity engaged in the business of insurance, including agents, brokers, adjusters and life insurance counselors.

(b) "Board" shall mean the Board of Insurance Commissioners of this state.

Sec. 3. *Unfair Methods of Competition or Unfair and Deceptive Act or Practices Prohibited.*—No person shall engage in this state in any trade practice which is defined in this Act as, or determined pursuant to this Act to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Sec. 4. *Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined.*—The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Misrepresentations and False Advertising of Policy Contracts. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statements as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance;

(2) False Information and Advertising Generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading;

(3) Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure any person engaged in the business of insurance;

(4) Boycott, Coercion and Intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance;

(5) False Financial Statements. . . .

(6) Stock Operations and Advisory Board Contracts. . . .

(7) Unfair Discrimination.

* * * *

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract

of accident or health insurance or in the benefits payable thereunder, or in any of the terms of conditions of such contract, or in any other manner whatever;

(8) Rebates. . . .

Sec. 5. *Power of Board.*—The Board shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair or deceptive act or practice prohibited by Section 3 of this Act.

Sec. 6. *Hearings, Witnesses, Appearances, Production of Books and Service of Process.*—(a) Whenever the Board shall have reason to believe that any such person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice defined in Section 4, and that a proceeding by it in respect thereto would be to the interest of the public, it shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than five days after the date of the service thereof;

(b) At the time and place fixed for such hearing, such person shall have an opportunity to be heard and to show cause why an order should not be made by the Board requiring such person to cease and desist from the acts, methods or practices so complained of. Upon good cause shown, the Board shall permit any person to intervene, appear and be heard at such hearing by counsel or in person;

(c) Nothing contained in this Act shall require the observance at any such hearing of formal rules of pleading or evidence;

(d) The Board, upon hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which it deems relevant to the inquiry. The Board, upon such hearing, may, and upon the request of any party, shall cause to be made a stenographic record of all the evidence and all the proceedings had at such hearing. If no stenographic record is made and if a judicial review is sought, the Board shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he may be lawfully interrogated, the District Court of Travis County or the county where such party resides, on application of the Board, may issue an order requiring such person to comply with such subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof;

* * * *

Sec. 7. *Cease and Desist Orders.*—(a) If, after such hearing under the terms of Section 6 of the Act, the Board shall determine that the method of competition or the act or practice in question is defined in Section 4 of this Article, or rules or regulations issued under this Article, or in Section 1746 of the Business & Commerce Code, as amended, and that the person complained of has engaged in such method of competition, act or practice in violation of this Article or rules and regulations issued under this Article or of the Deceptive Trade Practices—Consumer Protection Act (Sections 17.41 et seq., Business & Commerce Code), as specified in Section 17.46 of the Business & Commerce Code, it shall reduce its findings to writing and issue and cause to be served upon the

person charged with the violation an order requiring such person to cease and desist from engaging in such method of competition, act or practice.

* * * *

(c) Any person who violates the terms of a cease and desist order under this section shall be given notice to appear and show cause, at a hearing to be held in conformity with Section 6 of this Article, why he should not forfeit and pay to the state a civil penalty of not more than $1,000 per violation and not to exceed a total of $5,000. In determining whether or not a cease and desist order has been violated, the Board shall take into consideration the maintenance of procedures reasonably adapted to insure compliance with the order.

(d) An order of the Board awarding civil penalties under Subsection (c) of this section applies only to violations of this order incurred prior to the awarding of the penalty order.

* * * *

Sec. 10. *Penalty.*—Any person who violates a cease and desist order of the Board under Section 7, while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of Texas a sum not to exceed Fifty Dollars ($50.00), which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed Five Hundred Dollars ($500.00).

Sec. 11. *Provisions of Act Additional To Existing Law.*—The powers vested in the Board by this Act shall be additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

* * * *

Sec. 13. *Rules and Regulations.*—(a) The State Board of Insurance is authorized to promulgate and may promulgate and enforce reasonable rules and regulations and may order such provision as is necessary in the accomplishment of the purposes of this Article and Article 21.20, including, but not limited to, such express provision within the purposes of these Articles as it deems necessary or as is required to affect necessary uniformity with the laws of other states or the United States or in conformity with the adopted procedures of the National Association of Insurance Commissioners notwithstanding any previous definition or interpretation of terms and used in these Articles had in or derived from the common law or other statutory law of this state.

* * * *

Sec. 14. *Administrative Class Action.*—(a) In connection with the issuance of a cease and desist order as provided in Section 7 of this Article or upon application of any aggrieved person, the Board may, after notice and hearing as provided in Section 6 of this Article, in connection with the issuance of a cease and desist order resulting from a finding that an insurer has engaged in a method of competition, act or practice in violation of this Article, rules or regulations issued under this Article, or Section 17.46, Business & Commerce Code, as amended, or upon finding by the Board that the aggrieved person and persons similarly situated were induced to purchase a policy of insurance as a result of the insurer engaging in a method of competition, act or practice in violation of this Article, rules or regulations issued under this Article or Section 17.46, Business & Commerce Code, as amended, the Board may require the insurer to account for all premiums collected for policies issued during the immediately preceding two years in connection with such acts in violation of this Article and require: (i) such insurer to give notice to all persons from whom

such premiums were collected, and (ii) to refund the total of all premiums collected from each such person, electing to accept a premium refund in exchange for cancellation of the policy of insurance issued. Premiums so refunded shall be net of policy benefits actually paid by such insurer while the policy of insurance was in force. The Board shall specify a reasonable time within which the insurer shall be required to make such premium refunds.

(b) If an insurer fails to comply with the Board's requirement to refund such premiums within the time specified, the Board may, in addition to any other sanctions provided for in the Insurance Code and other applicable laws, report such failure to the Attorney General and request the Attorney General to file a suit to enforce the Board's requirement for refund of premiums. Venue for such suit shall lie in the District Court of Travis County, Texas, and upon finding by the court that such requirement of the Board was lawfully entered and that the insurer has failed to comply with such requirement, the Court shall enter an appropriate order to enforce such Board order. The Court may enforce its order through contempt proceedings.

* * * *

Sec. 15. *Injunctions.*—(a) If the Board has reason to believe that any person in the insurance business in this state is engaging in, has engaged in, or is about to engage in any act or practice declared to be unlawful by this Article or rules or regulations issued under this Article or by Section 17.46 of the Business & Commerce Code, as amended, and that proceedings would be in the public interest, the Board may request the Attorney General to bring an action in the name of the state against the person to restrain by temporary or permanent injunction the use of such method, act, or practice.

* * * *

(c) In addition to the request for a temporary or permanent injunction in a proceeding brought under Subsection (a) of this section, the Attorney General, on a finding by the court that the defendant has engaged or is engaging in a practice declared to be unlawful by Article 17.46 of the Business & Commerce Code, as amended, this Article, or rules or regulations issued under this Article, may request a civil penalty of not more than $2,000 per violation and not to exceed a total of $10,000 to be paid to the state.

(d) The court may make such additional orders or judgments as are necessary to compensate identifiable persons for actual damages or restoration of money or property, real or personal, which may have been acquired by means of any act or practice restrained. Damages may not include any damages incurred beyond a point two years prior to the institution of the action.

(e) Any person who violates the terms of an injunction under this section shall forfeit and pay to the state a civil penalty of not more than $10,000 per violation not to exceed $50,000. In determining whether or not an injunction has been violated the court shall take into consideration the maintenance of procedures reasonably adapted to insure compliance with the injunction. For the purposes of this section, the district court issuing the injunction shall retain jurisdiction, and the cause shall be continued, and in such cases, the Attorney General with prior notice to the Board, acting in the name of the state, may petition for recovery of civil penalties under this section.

* * * *

Sec. 16. *Relief Available to Injured Parties.*—(a) Any person who has been injured by another's engaging in any of the practices declared in Section 4 of this Article to be unfair methods of competition and unfair and deceptive acts or practices in the business of in-

surance or in any practice defined by Section 17.46 of the Business & Commerce Code, as amended, as an unlawful deceptive trade practice may maintain an action against the company or companies engaging in such acts or practices.

(b) In a suit filed under this section, any plaintiff who prevails may obtain:

(1) three times the amount of actual damages plus court costs and attorneys' fees reasonable in relation to the amount of work expended;

(2) an order enjoining such acts or failure to act;

(3) any other relief which the court deems proper.

(c) On a finding by the court that an action under this section was groundless and brought in bad faith or for the purpose of harassment, the court may award to the defendant reasonable attorneys' fees in relation to the amount of work expended.

(d) In an action under this section, damages may not include any damages incurred beyond a point two years prior to the institution of the action.

Sec. 17. *Class Actions.*—(a) If a member of the insurance buying public has been damaged by an unlawful method, act, or practice defined in Section 4 of this Article or by the rules and regulations lawfully adopted by the Board under this Article or by any practice defined by Section 17.46 of the Business & Commerce Code, as amended, as an unlawful deceptive trade practice, the Board may request the Attorney General to bring a class action, or the individual damaged may bring an action on behalf of himself and others similarly situated, to recover damages and relief as provided in this section.

(b) A plaintiff who prevails in a class action under this section may recover:

(1) court costs and attorneys' fees reasonable in relation to the amount of work expended in addition to actual damages;

(2) an order enjoining the act or failure to act;

(3) any other relief which the court deems proper.

(c) On a finding by the court that an action under this section was brought by an individual plaintiff in bad faith or for the purpose of harassment, the court may award to the defendant reasonable attorneys' fees in relation to the work expended and court costs.

(d) In an action under this section, damages may not include any damages incurred beyond a point two years prior to the institution of the action.

(e) An action under this section may not be maintained if an administrative class action under Section 14 of this Article has been initiated or has resulted in a final determination regarding the same acts or practices and the same defendant in the action under this section.

* * * *

Tex. Bus. & Comm. Code Ann. § 15.02 (1963)

Trust Defined

(a) In this section, unless the context requires a different definition "person" does not include municipal corporation.

(b) A "trust" is a combination of capital, skill, or acts by two or more persons to

(1) restrict, or tend to restrict, trade, commerce, the preparation of tangible personal property for market or transportation, or the free pursuit of a lawful business; or

(2) fix, maintain, increase, or reduce the price of tangible personal property, the cost of in-

surance, or the cost of preparing tangible personal property for market or transportation; or

(3) prevent or lessen competition in

(A) the manufacture, transportation, sale, or purchase of tangible personal property;

(B) the business of insurance;

(C) aids to commerce; or

(D) preparing tangible personal property for market or transportation; or

(4) affect, control, or establish the price of tangible personal property, or the cost of transportation, insurance, or preparing tangible personal property for market or transportation; or

(5) agree

(A) not to sell, dispose of, transport, or prepare tangible personal property for market or transportation, or not to make an insurance contract, at a price below a common standard or figure;

(B) to maintain the price of tangible personal property, the charge for transportation or insurance, or the cost of preparing tangible personal property for market or transportation at a fixed or graded figure;

(C) to affect or maintain the price of tangible personal property or the cost of transportation, insurance, or preparing tangible personal property for market or transportation in order to preclude

free competition between or among themselves or others in the sale or transportation of tangible personal property, in the business of transportation or insurance, or in preparing tangible personal property for market or transportation; or

(D) to pool, combine, or unite an interest they have in the sale or purchase of tangible personal property, or in the charge for transportation, insurance, or preparing tangible personal property for market or transportation, so that the price of the tangible personal property, or charge for transportation, insurance, or preparing tangible personal property for market or transportation, might be in any manner affected; or

(6) regulate, fix, or limit the output of tangible personal property, or the amount of insurance undertaken, or the amount of work performed in preparing tangible personal property for market or transportation; or

(7) refrain from engaging in business, or from buying or selling tangible personal property, partially or entirely in this state.

Tex. Bus. & Comm. Code. Ann. § 15.04 (1963)

Monopoly, Trust, and Conspiracy in Restraint of Trade Prohibited; Agreement Violating Prohibition Void

(a) Every monopoly, trust, and conspiracy in restraint of trade, as defined in Sections 15.01, 15.02, and 15.03 of this code, respectively, is illegal and prohibited.

(b) An agreement violating the prohibition against a monopoly, trust, or conspiracy in restraint of trade contained in Subsection (a) of this section is void and unenforceable in law or equity.

Tex. Bus. & Comm. Code Ann. § 15.29 (1963)

Charter of Domestic Corporation Forfeited

(a) When he believes the public interest requires it, the attorney general shall file suit to forfeit the charter or articles of incorporation of a domestic corporation which has violated or is violating the prohibition contained in Section 15.04 of this code. The attorney general may file suit under this subsection in a district court in any county in the state.

Tex. Bus. & Comm. Code Ann. § 15.32 (1963)

Monetary Penalty

(a) A person adjudged guilty of violating the prohibition contained in Section 15.04 of this code shall pay a fine to the state of not less than $50 nor more than $1,500 for each day of violation. The attorney general, or a district, criminal district, or county attorney acting under his direction, shall represent the state in a suit filed to collect this fine.

Tex. Bus. & Comm. Code Ann. § 15.33 (1963)

Criminal Penalties

(a) A person may not agree to form, form, be a party to the formation of, or aid a monopoly, trust, or conspiracy in restraint of trade, as defined in Sections 15.01, 15.02, and 15.03(a)(1)-(3) of this code, respectively.

Supreme Court, U. S.
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MICHAEL RODAK, JR., CLERK

In the

Supreme Court of the United States

October Term, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY a/k/a BLUE SHIELD and/or BLUE CROSS-BLUE SHIELD OF TEXAS, WALGREEN TEXAS COMPANY, THE SOMMERS DRUG STORES COMPANY, RIEGER/MEDI-SAVE PHARMACIES, INC. d/b/a GIBSONS PHARMACY,

Petitioners,

v.

ROYAL DRUG COMPANY, INC. d/b/a ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, BLAUSER'S PHARMACY, INC., PARKERS PHARMACY, INC., CRAIG BELL d/b/a BELL PHARMACY, GEORGE STONE d/b/a OLMOS PHARMACY, HIGHLAND HILLS PHARMACY, INC., ECONODOSE SYSTEMS, INC. d/b/a MEDICAL CENTER PHARMACY, GUSTAVE HNCIR d/b/a TURNERS PHARMACISTS, CARLOS DIAZ d/b/a VALLEY VIEW PHARMACY, ALFRED SANGALLI d/b/a STAR DRUG STORE, BLANCO PHARMACY, INC., BLANCO SOUTHSIDE PHARMACY, INC., DAN PARADA d/b/a DAN'S PHARMACY, RODOLFO L. DAVILA, INC. d/b/a DAVILA PHARMACY, DELLMAR PHARMACY #4, RONG, INC. d/b/a ECONOMY PHARMACY #1, ZARZAMORA, PHARMACY, INC., and WHITE CROSS PROFESSIONAL PHARMACY, INC. d/b/a WHITE CROSS #1 and d/b/a WHITE CROSS #4,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR RESPONDENTS

TINSMAN & HOUSER, INC.,
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Commerce Bldg.,
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In the

Supreme Court of the United States

October Term, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY a/k/a BLUE SHIELD and/or BLUE CROSS-BLUE SHIELD OF TEXAS, WALGREEN TEXAS COMPANY, THE SOMMERS DRUG STORES COMPANY, RIEGER/MEDI-SAVE PHARMACIES, INC. d/b/a GIBSONS PHARMACY,

Petitioners,

v.

ROYAL DRUG COMPANY, INC. d/b/a ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, BLAUSER'S PHARMACY, INC., PARKERS PHARMACY, INC., CRAIG BELL d/b/a BELL PHARMACY, GEORGE STONE d/b/a OLMOS PHARMACY, HIGHLAND HILLS PHARMACY, INC., ECONODOSE SYSTEMS, INC. d/b/a MEDICAL CENTER PHARMACY, GUSTAVE HNCIR d/b/a TURNERS PHARMACISTS, CARLOS DIAZ d/b/a VALLEY VIEW PHARMACY, ALFRED SANGALLI d/b/a STAR DRUG STORE, BLANCO PHARMACY, INC., BLANCO SOUTHSIDE PHARMACY, INC., DAN PARADA d/b/a DAN'S PHARMACY, RODOLFO L. DAVILA, INC. d/b/a DAVILA PHARMACY, DELLMAR PHARMACY #4, RONG, INC. d/b/a ECONOMY PHARMACY #1, ZARZAMORA PHARMACY, INC., and WHITE CROSS PROFESSIONAL PHARMACY, INC. d/b/a WHITE CROSS #1 and d/b/a WHITE CROSS #4,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR RESPONDENTS

Respondents, ROYAL DRUG COMPANY, INC. d/b/a ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, BLAUSER'S PHARMACY, INC., PARKERS PHAMACY, INC., CRAIG BELL

d/b/a BELL PHARMACY, GEORGE STONE d/b/a OLMOS PHARMACY, HIGHLAND HILLS PHARMACY, INC., ECONODOSE SYSTEMS, INC. d/b/a MEDICAL CENTER PHARMACY, GUSTAVE HNCIR d/b/a TURNERS PHARMACISTS, CARLOS DIAZ d/b/a VALLEY VIEW PHARMACY, ALFRED SANGALLI d/b/a STAR DRUG STORE, BLANCO PHARMACY, INC., BLANCO SOUTHSIDE PHARMACY, INC., DAN PARADA d/b/a DAN'S PHARMACY, RODOLFO L. DAVILA, INC. d/b/a DAVILA PHARMACY, DELLMAR PHARMACY #4, RONG, INC. d/b/a ECONOMY PHARMACY #1, ZARZAMORA PHARMACY, INC., and WHITE CROSS PROFESSIONAL PHARMACY, INC. d/b/a WHITE CROSS #1 and d/b/a WHITE CROSS #4, request that the Court affirm the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit is reported at 566 F. 2d 1375. The opinion of the United States District Court for the Western District of Texas is reported at 415 F. Supp. 343. The Court of Appeals and District Court opinions are reproduced at pages 117a-138a and 100a-115a of the Appendix ("App.')

QUESTIONS PRESENTED

Petitioners have posed the following as the question for review:

> [W]hether the "business of insurance," within the meaning of the antitrust exemption afforded by the McCarran Act, includes a contract between an insurer and a health care provider to furnish benefits owed to policyholders under the insurer's health care policies. (Brief for Petitioners at 2).

Respondents respectfully submit that the global question articulated by Petitioners is not the question to be decided by the Court. Nevertheless, it is instructive to critically analyze Petitioners' question against the backdrop of Petitioners' actu[illegible]nduct and activities. Such analysis underscores the mockery Petitioners desire to make of the McCarran-Ferguson Act and the threat their activities pose to competition and to continued survival of small independent business in this country.

Respondents have not contended, and the United States Court of Appeals for the Fifth Circuit (the Fifth Circuit) did not hold that all contracts between insurers and health care providers *to furnish benefits owed to policyholders* are outside the "business of insurance." The real issue is whether there is a blanket McCarran-Ferguson Act exemption for contracts between insurers and providers of benefits, which *ipso facto* exempts from federal antitrust scrutiny any and all activities the ingenuity of insurers can implement through such contracts. Congress never intended to blindfold the courts in the manner desired by Petitioners. The individual activities embodied within or implemented through the contract with providers must be scrutinized to determine whether they, regardless of the camouflage or window dressing, actually are part of the "business of insurance." In this regard, there are actually four questions to be determined by the Court. They are as follows:

1. Whether Petitioners' activities in combining and conspiring to fix the retail sales prices of pharmaceuticals, in conspiring to effect a boycott of pharmacy owners who refuse to fix prices, and in conspiring to foreclose pharmacy owners who refuse to fix prices from a substantial portion of the market constitute the "business of insurance."

2. Whether Texas' entire want of regulation in the area of Petitioners' anticompetitive activities renders the Sherman Act applicable to such activities.
3. Whether the existence of boycott, coercion, and intimidation eliminates the immunizing effects of the McCarran-Ferguson Act in this case.
4. Whether retail pharmacy chains can avoid the Sherman Act's proscriptions by combining with an insurance company and utilizing it as an intermediary to eliminate price and other forms of competition in the retail pharmaceutical industry.

STATEMENT OF THS CASE

Respondents are eighteen (18) independent retail pharmacy owners doing business in Bexar County, Texas. Petitioners include an insurance company, GROUP LIFE AND HEALTH INSURANCE COMPANY (Blue Shield), which sells life, health and accident insurance policies *for profit* (App. 300a); and three retail pharmacy chains, WALGREEN TEXAS COMPANY (Walgreens), THE SOMMERS DRUG STORES COMPANY (Sommers), and RIEGER/MEDI-SAVE PHARMACIES, INC. (Rieger), which operate retail pharmacies in Bexar Ccunty, Texas.

Respondents brought this action seeking redress for Petitioners' activities in violation of section 1 of the Sherman Act, 15 U.S.C. §1 (1970). In reliance on the McCarran-Ferguson Act, 15 U.S.C. §1011 *et. seq.* (1970), the District Court granted a summary judgment for Petitioners. The United States Court of Appeals for the Fifth Circuit reversed, holding that the activities challenged by Respondents are not a part of the business of insurance.

A. Petitioners' Anticompetitive Activities

In 1969, Blue Shield first offered prescription drug insurance coverage to certain groups in Texas as a supplemental

policy to its group medical-surgical insurance policies. (Depo. of Judith J. Johnson ("Johnson Depo.") at 9-10, App. 143a)[1]. A copy of this supplemental policy (the Prescription Drug Insurance Policy) is set forth at pages 303a-310a of the Appendix. (McDonald Depo. Exhibit 37). Prior to 1969, Blue Shield had not offered similar coverage. (Johnson Depo. at 12, App. 145a). With the minor changes in wording as reflected in pages 311a-318a of the Appendix (McDonald Depo. Exhibit 39), Blue Shield has continued to market the Prescrpition Drug Insurance Policy in Texas. In recent years, the number of pharmaceutical sales covered by this policy have risen dramatically. Between early 1972 and October, 1975, alone, there was a 3,100% increase in the number of pharmaceutical claims processed by Blue Shield under the policy. In October, 1975, Blue Shield was handling these claims at the rate of approximately 31,000 claims per month as compared with only 1,000 claims per month in early 1972. (Deposition of Lee Helis (Helis Depo.) at 9-10, App. 280a-281a).[2]

Contemporaneous to its making this insurance available, Blue Shield contacted retail pharmacies concerning their entering into a Participating Drug Pharmacy Agreement (The Pharmacy Agreement). A copy of The Pharmacy Agreement is set forth at pages 200a-204a of the Appendix.

---

[1] Ms. Johnson is Assistant Vice President of Medical Administration for Group Hospital Service, Inc. and Group Life and Health Insurance Company (Blue Cross-Blue Shield of Texas). She is responsible for the on-going administration of the Blue Shield Prescription Drug Program with pharmacies as it relates to enrolling participating pharmacies and has been employed by Blue Cross-Blue Shield of Texas for twenty-six years. (Johnson Depo. at 4-6, App. 141a-143a).

[2] Mr. Helis is manager of regular claims for Blue Cross-Blue Shield of Texas.

(Johnson Depo. Exhibit 19). It has not changed since its inception in 1969.[3] (Johnson Depo. at 13, App. 145a).

Petitioners innocuously describe The Pharmacy Agreement as follows:

> [T]he mechanism through which prescription drug benefits are provided to insureds in accordance with Blue Shield's obligations under the policy. (Brief for Petitioners at 4).

As is discussed extensively *infra*, it is neither the purpose nor the effect of The Pharmacy Agreement to serve as a "mechanism through which prescription drug benefits are provided to insureds." Rather, as is evident from its provisions, The Pharmacy Agreement is purely and simply a price fixing agreement. Pursuant to paragraph 4 of the instrument, the participating pharmacy agrees to set its retail sales prices for all sales of prescription pharmaceuticals to Blue Shield's subscribers at an amount equal to the pharmacy's acquisition cost for the particular drug plus a "professional dispensing fee of $2.00". (Johnson Depo. Exhibit 19, App. 201a-202a). That the Agreement is merely a price fixing agreement is further reinforced by Blue Shield's own construction thereof. On Page II-2 of Blue Shield's Pharmacy Manual, it defines a "Participating Provider" (a pharmacy that has signed The Pharmacy Agreement) as follows:

> A Provider who has entered into a Participating Contract with Blue Shield of Texas to provide a Covered Drug at a cost to a subscriber not to exceed the Copayment Amount of $2.00 and *a total payment from Blue Shield and the subscriber not to exceed the cost of the Covered Drug plus a dispensing fee (of $2.00).* (Johnson Depo. Exhibit 2, App. 169a) (emphasis added).[4]

[3] The Pharmacy Agreement mentioned by Petitioners on page 4 of their brief, which appears at App. 59a-61a, differs from the Pharmacy Agreement actually utilized with Texas pharmacies. Compare App. 59a-61a with App. 200a-204a. Unless otherwise indicatd, Respondents' references to The Pharmacy Agreement refer to the Agreement as reproduced at App. 200a-204a.

Significantly, in describing a pharmacy that has signed The Pharmacy Agreement, Blue Shield finds it salient to describe only one characteristic of the Agreement — the pharmacy's obligation to charge its costs, as defined, plus a fixed, uniform dispensing fee. Each of the "Participating Pharmacies" knows that those of his competitors who sign the Pharmacy Agreement will be charging the same prices (Johnson Depo. Exhibit 2 at II-7, App. 175a) and that Blue Shield will not deal with a pharmacist who has refused to agree on prices. (Johnson Depo. Exhibit 2 at II-7, App. 176a). The Prescription Drug Insurance Policy does not require price fixing, but only that participating pharmacies agree to furnish covered drugs.

The pharmacies that sign The Pharmacy Agreement can charge no more for their prescription drugs than the amount specified therein, regardless of the magnitude of a particular drug's acquisition cost. (Johnson Depo. at 40, 53-55, App. 153a-155a). Thus, the participating pharmacy is limited to a $2.00 markup (the "professional dispensing fee") whether its actual acquisition cost for a particular drug is $8.00 or $80.00. With respect to specialized and highly expensive pharmaceuticals, The Pharmacy Agreement can result in the pharmacy owner's being allowed a mark-up that will not even cover the interest on his investment in inventory .

[4] Page II-6 of Blue Shield's Pharmacy Manual provides that the "dispensing fee" in Texas shall be $2.00. (Johnson Depo. Exhibit 2, App. 175a).

The retail sales price, as fixed in The Pharmacy Agreement between Blue Shield and the Petitioner pharmacy chains, has been set at a level below that at which small independent pharmacies can profitably conduct business. Only large, high volume chains that sell many items in addition to pharmaceuticals can afford to operate pursuant to The Pharmacy Agreement. Unlike the small independent pharmacy, the large chains often view the prescription counter as a peripheral item — the sale of prescription pharmaceuticals is a "loss-leader" to attract customers into the store where they can purchase other items while waiting for their prescriptions to be filled.[5] To the small independent retail pharmacist, on the other hand, dispensing prescriptions is the essence of his business. The profits derived from this service are the basis of his income and enable him to continue operating as a businessman.

In addition to fixing the retail sales price for pharmaceuticals at a level that denies the small independent pharmacist a profit, The Pharmacy Agreement sets the retail sales price for pharmaceuticals at a level that eliminates the small independent pharmacies' one effective means for

[5] In a recent newspaper advertisement, Petitioner Sommers advertised the following items for sale in its discount "drug stores": Spalding Tennis Set, Golden Ram Golf Balls, Delux Car Caddy with CB Mike Holder, beach towels, plastic coated playing cards, The Shower Massage by Water Pik, Casio LC-88 thin electronic calculator, Schlitz beer, Lone Star beer, Gallo Hearty Burgandy, Swinger II Bar-B-Que Grill, an Hibachi, 3-pc. Bar-B-Que tool set, garden tools, 2 gallon gas can, Donald Duck sprinkler, sprinkler assortment, Kodak Extra I Camera Outfit, Dana Solid Cologne, Aviance Spray Cologne, 6 pack cans of Coke and Sprite, Fritos Corn Chips, 48 quart ice chest, GAF 126 12 exposure color film, Cozy Cup holder, coloring books, Right Guard Deodorant, Schick Super II Razor, L'Oreal Preference Shampoo and Revlon Nail Polish. San Antonio Express, June 6, 1978, at 9-A.

competing with the large chains — the provision of services. Signatories of The Pharmacy Agreement are limited to the same retail sales price whether they provide home deliveries, twenty-four hour-a-day emergency service, patient profile cards to monitor drug usage, patient advice,[6] or no service at all (Johnson Depo. at 55, App. 155a). Since the sales price is set by The Pharmacy Agreement at a level that does not enable the small independent pharmacies to provide extra services, their ability to compete is effectively destroyed.

The Pharmacy Agreement's vice is not solely the elimination of price competition. It eliminates competition in services as well and constitutes a per se violation of Section 1 of the Sherman Act, 15 U. S. C. §1 (1970). Each of the Petitioner pharmacy chains has executed one or more Pharmacy Agreements (Johnson Depo. at 68, App. 156a-157a), and otherwise combined and conspired with Blue Shield, and with each other, to fix the retail sales prices for prescription pharmaceuticals.

Blue Shield's plan of operation does not encompass merely the fixing of the Petitioner pharmacy chains' prices. It contemplates the fixing of retail sales prices in the retail pharmacy industry generally through coercion of the small independent pharmacies. The small independent pharmacies are given the choice of either signing the price fixing

[6] Pharmacies vary in the amount of professional advice they provide prescription patients. Some merely dispense pharmaceuticals with little or no patient contact. Others give the advice needed to insure the patient takes the medication at the proper time and in the proper regime to obtain full therapeutic effects; advice to prevent the patient's ingesting other drugs or foods that will alter the effect of the medication, either potentiating or nullifying the effects; advice that will insure the patient's recognition of untoward effects of medications; and myriad other forms of advice, including merely a sympathetic ear.

agreement or being eventually forced from business. In reality, the choice is no choice, since the result of their signing the price fixing agreement is also eventual elimination.

The coercion of the small independent pharmacies is clearly economic in nature and is brought about by the Petitioners' conspiracy to effect a boycott by Blue Shield's subscribers of the non-signing pharmacies and by their conspiracy to foreclose such pharmacies from a substantial portion of the market. A pharmacy that refuses to sign the price fixing agreement is effectively foreclosed from making further pharmaceutical sales to Blue Shield's subscribers, who are coerced not to patronize the non-signer.

Coercion of the subscriber is two-pronged. First, the subscriber receives markedly reduced benefits if he patronizes a pharmacy that refuses to sign the price-fixing agreement. While he is required to pay only a Two Dollar ($2.00) drug deductible for each prescription filled by a "participating" pharmacy, he must ultimately pay an amount representing 25% of a "reasonable charge" for the drug, "as determined by Blue Shield Shield," in addition to the Two Dollar ($2.00) drug deductible, for each prescription filled by a non-signing pharmacy. (Article III of McDonald Depo. Exhibit 39, App. 315a-316a). This monetary penalty for patronizing a pharmacy that refuses to sign the price fixing agreement arises because Blue Shield will reimburse the subscriber only 75% of a "reasonable charge" for the drug, "as determined by Blue Shield," less the $2.00 drug deductible, when non-signing pharmacies are patronized. *Id.* Deposition testimony revealed no studies by Blue Shield that would justify this differential in benefits. Johnson Depo. at 27, App. 148a).

Obviously, the differential in benefits is intended to coerce Blue Shield's policyholders not to patronize non-signing pharmacies in Texas and thereby to coerce such pharmacies to sign the price fixing agreement. This purpose of coercion is graphically illustrated by Article III, Paragraph B of the Prescription Drug Insurance Policy, which provides that the subscriber will be reimbursed *100% of a "reasonable charge"* for the drug, less the $2.00 drug deductible, *when he patronizes a non-signing pharmacy outside the State of Texas.* (McDonald Depo. Exhibit 39, App. 316a; Johnson Depo. Exhibit 2 at III-7, App. 184a). There could be no reason for distinguishing between non-signing pharmacies inside versus those outside Texas, other than the fact that coercion of the latter would serve no useful purpose for Blue Shield. It would not be feasible to contract with all of the pharmacies outside of Texas.

Petitioners attempt to justify the differential in benefits by arguing that "[t]he administrative costs of processing claims for drugs purchased from non-participating pharmacies are higher than for those purchased from participating pharmacies." (Brief for Petitioners at 5, n.5). If Blue Shield's motivation were truthfully higher administrative costs, then benefits should be the same for prescription drugs purchased at non-signing pharmacies outside or inside Texas. It is curious that Blue Shield could think of this excuse for discriminating in benefits when writing its brief while Judith Johnson, Assistant Vice President of Medical Administration responsible for administration of the Blue Shield Prescription Drug Program, could not think of a reason for the discrimination in benefits while giving her oral deposition. (Johnson Depo. at 27, 34-35; App. 148a, 151a.)

The argument concerning higher administrative costs is a red herring that has been carefully orchestrated by Petitioners. To the extent they exist, the higher administrative costs have been intentionally created and perpetuated by Blue Shield's refusal to deal with pharmacies that will not agree to fix prices. By refusing to deal with pharmacies that will not sign the price fixing agreement, Blue Shield gives itself an excuse to discriminate in benefits and thereby pressure its subscribers to boycott non-signing pharmacies.

Blue Shield's refusal to deal with non-signing pharmacies provides Petitioners with an additional and more subtle tool with which to coerce Blue Shield's subscribers and thereby effectuate a boycott of non-signers. If a pharmacy signs The Pharmacy Agreement and thereby agrees to charge only the stipulated amount for pharmaceuticals sold to Blue Shield's subscribers, it will be reimbursed by Blue Shield in the amount of its acquisition cost for the drug, and the subscriber will be obligated to personally pay the pharmacy at the time of purchase only the Two Dollar ($2.00) drug deductible (in effect, the "professional dispensing fee"). (Paragraph 4 of Johnson Depo. Exhibit 19, App. 210a-202a, and Johnson Depo. Exhibit 2 at p. II-7, App. 175a-176a). However, when a pharmacy refuses to sign the price fixing agreement, Blue Shield will not deal with the pharmacy directly, and the subscriber must pay the entire retail sales price at the time of purchase rather than merely the Two Dollar ($2.00) deductible that he would pay a participating pharmacy. (Johnson Depo. Exhibit 2 at p. II-7, App. 175a-176a). After paying the entire sales price at the time of purchase, he must file a claim with Blue Shield seeking reimbursement (which will equal only seventy-five percent (75%) of a "reasonable charge" for the drug, "as determined by Blue Shield," less the Two

Dollar ($2.00) drug deductible. (Johnson Depo. Exhibit 39 at Article III.B, 316a).

The pressures exerted on the subscriber are obvious. If he patronizes a pharmacy that has signed the price fixing agreement, he does not tie up his money during the often long interval that passes in obtaining reimbursement from Blue Shield. Additionally, he avoids the administrative burden of his filing a claim for reimbursement. That these pressures are aimed at coercing the subscribers not to patronize the non-signing pharmacies, and thereby to coerce such pharmacies to sign the price fixing agreement, cannot be doubted. Regardless whether the subscriber patronizes a signing or non-signing pharmacy, the same claim form is utilized (Helis Depo. at 15, App. 282a; Johnson Depo. Exhibit 2 at p. III-4, App. 180a); the same information is necessary to its completion; and the pharmacist's assistance is needed in providing this information. (Johnson Depo. Exhibit 2 at p. III-4 to III-6, App. 180a-184a). Indeed, the claim form itself directs the insured to have the non-participating pharmacy complete the prescription information section (Johnson Depo. Exhibit 2 at p. III-4, App. 180a-181a). Thus, since the pharmacy must participate in claims administration in both instances, no purpose is served by Blue Shield's refusal to deal directly with non-participating pharmacies other than the harassment of its policyholders. When the policyholder files his own claim, it is more involved for him than if he had patronized a participating pharmacy, who would file the claim for him, and he must await reimbursement. (Helis Depo. at 22-23, App. 285a-286a).

Although Petitioners claim that "Blue Shield's insureds are *entitled* to obtain prescription drugs from any pharmacy

they choose,"[7] it is a rare subscriber indeed who is willing to accept reduced benefits and to undergo an administrative burden in order to patronize the pharmacy of his choice. Since the Prescription Drug Insurance Policy gives the subscriber far more monetary and administrative benefits when he patronizes a Participating Pharmacy than when he patronizes a pharmacy that has refused to to sign the price fixing agreement, he is subtly, but actually, coerced to purchase pharmaceuticals solely from Participating Pharmacies.

The effectiveness of this coercion is documented. Of the 31,000 prescription claims per month processed by Blue Shield in late 1975, approximately 600 per month, or *merely 1.9%*, represented prescriptions filled by non-participating pharmacies. (Helis Depo. at 10, 13; App. 281a-282a). Thus, through the aforementioned methods of coercion, Petitioners have effectively allocated to the signatories of the price fixing agreement *over 98%* of all sales of prescription pharmaceuticals to Blue Shield's subscribers. The program of coercion effectively forecloses the non-signing pharmacies from a substantial portion of the market and, therefore, constitutes an unreasonable restraint of trade in violation of Section One of the Sherman Act. 15 U.S.C. §1 (1970).

The Petitioner pharmacy chains play a central role in the conspiracy to set the retail sales prices of pharmaceuticals, the conspiracy to effect a boycott of Respondents, and the conspiracy to foreclose Respondents from a substantial portion of the market. It is only through the participation of the Petitioner pharmacy chains that the small independent pharmacies can be whipsawed into agreeing to fix their retail sales prices.

[7] Brief for Petitioners at 4 (emphasis added).

By combining with the Petitioner pharmacy chains, who have many outlets, Blue Shield has guaranteed that its subscribers will not have to choose between geographical inconvenience and reduced policy benefits when deciding whether to patronize a non-signing pharmacy. The subscriber will generally find one of the Petitioner chains' outlets to be readily accessible. The large chains help guarantee that the sole factors in the subscriber's mind will be the markedly reduced policy benefits and administrative inconvenience he will receive if he patronizes a non-signing pharmacy.

Blue Shield has consciously utilized these factors as can be seen in its inter-office correspondence. When a particular large drug chain, Sommers, decided to join the price fixing conspiracy, one member of Blue Shield's management admitted, "Our entire Foundation Program [Bexar County] would not have been successful without them. . . ."[8] (Johnson Depo. Exhibit 13, App. 199a; Johnson Depo. at 61, App. 156a). *See also*, Johnson Depo. Exhibit 12, App. 198a.

B. Respondents' Answer to Petitioners' "History of the Drug Insurance Program"

Petitioners seek to avoid scrutiny of their activities under the Sherman Act by alleging that their conduct merely is the "business of insurance" and falls within the protective umbrella of the McCarran-Ferguson Act (McCarran Act), 15 U. S. C. §§1011, *et seq.*, (1970). In furtherance of this thesis, Petitioners make numerous erroneous representations concerning the extent and types of regulation to which their activities have been subjected by the State of Texas.

[8] At the time Judith Johnson's deposition was taken in 1975, Petitioner Sommers had twenty-five (25) stores in San Antonio, Texas. (Johnson Depo. Exhibit 17, Johnson Depo. at 62-63, 66).

Petitioners obviously desire to create the impression that their challenged activities are considered part of the "business of insurance" by the State of Texas and have been regulated as part of that business. Such is not the case!

The most blatant misstatements of fact set forth in Petitioners' brief are Petitioners' assertions that the State Board of Insurance and/or its Commissioner have "authorized", "approved", and "regulated" The Pharmacy Agreement and its attendant price fixing activities. *See* Brief for Petitioners at 7, 8, 31-35. Petitioners assert that Blue Shield filed the Prescription Drug Insurance Policy *and* The Pharmacy Agreement with the Texas State Board of Insurance "for approval." (Brief for Petitioners at 7). They assert that in 1969, the State Board issued an order "disapproving" The Pharmacy Agreement. *Id.* at 7, 33. Further, they state that following disapproval The Pharmacy Agreement remained under consideration by the State Board, with "authorization" for its issuance and use coming in September, 1969. *Id.* They represent that The Pharmacy Agreement has been subjected to "pervasive regulation" by the Texas State Board of Insurance.

Petitioners' statements in this regard are utterly erroneous, have no foundation in fact, and are misleading. Although Petitioners make numerous allegations concerning The Pharmacy Agreement's being "regulated" and subject to "pervasive regulation," they fail to show a *single example* of such "regulation." Petitioners are trying to create the illusion that The Pharmacy Agreement and, more specifically, its attendant price fixing in the pharmaceutical industry are considered by Texas to be within the jurisdiction of the State Board of Insurance and thus a part of the business of insurance.

The Pharmacy Agreement and its attendant price fixing have never been approved, authorized, nor regulated by the Board. The Board has never purported to have authority or jurisdiction to authorize or regulate The Pharmacy Agreement nor Blue Shield's price fixing conspiracies with pharmacies. In this regard, it is crucial that the Court distinguish between the Prescription Drug Insurance Policy (McDonald Depo. Exhibits 37, 39; App. 303a-318a) and The Pharmacy Agreement (Johnson Depo. Exhibit 19, App. 200a-204a) when reviewing Petitioners' brief in order that it is not misled into thinking that the latter document had been approved, authorized, or regulated.

Blue Shield endeavors to create the illusion of State regulation by stating the following:

> In March, 1969, in compliance with the requirements of Article 3.42 of the Texas Insurance Code, TEX. INS. CODE ANN. art. 3.42 (Supp. 1977) . . ., Blue Shield filed the proposed policy *and the annexed Pharmacy Agreement* with the Texas State Board of Insurance ("State Board") *for approval.* (Brief for Petitioners at 7) (emphasis added).

By stating that The Pharmacy Agreement was submitted *for approval* in March, 1969, Blue Shield is trying to create the illusion that The Pharmacy Agreement is within the jurisdiction of the State Board of Insurance and regulated as a part of the business of insurance in Texas. It is obviously trying to create the impression that The Pharmacy Agreement must be submitted to the Board for approval prior to its use. Such is not the case!

Article 3.42 merely requires the filing of the "forms" of the "policy, contract, or certificate of . . . group hospitalization insurance, medical or surgical insurance, group medical

or surgical insurance. . . ." TEX. INS. CODE ANN. art 3.42 (Supp. 1977). Nowhere does it require the filing of The Pharmacy Agreement nor an equivalent document. There are no Texas statutes that require The Pharmacy Agreement to be submitted to the State Board of Insurance "for approval" or for any other reason.

Blue Shield is well aware that The Pharmacy Agreement does not have to be submitted to the State Board "for approval." Steve G. McDonald, house counsel for Blue Shield (McDonald Depo. at 4, App. 288a), and the individual who supposedly submitted The Pharmacy Agreement to the State Board of Insurance in March, 1969, "for approval", admitted in his oral deposition that approval of the State Board of Insurance is not required with respect to use of The Pharmacy Agreement. (McDonald Depo. at 57, App. 302a). He further admitted that The Pharmacy Agreement was "filed with the Insurance Board for informational purposes," not for approval. *Id.* Indeed, Blue Shield's March, 1969, transmittal letter to the Board itself demonstrates that The Pharmacy Agreement was not submitted "for approval." The only document submitted "for approval" in the letter was Form No. CC-OHDS-2, the Prescription Drug Insurance Policy. (Pogue Depo. Exhibit 51, App. 352a-353a).

The allegations set forth in Petitioners' brief concerning "approval" and "authorization" of The Pharmacy Agreement merely are a continuation of the charade Blue Shield has endeavored to perpetuate since its first contemplated use of The Pharmacy Agreement to fix prices. This charade is graphically illustrated by some early correspondence between the president of Blue Shield of Texas and an official of the National Association of Blue Shield Plans

concerning preparation of what was to become Blue Shield's Pharmacy Agreement. *See* Johnson Depo. Exhibit 32, App. 276a-277a. A copy of this exhibit is reproduced as Addendum ("Add.") No. 1 to this brief.

As the correspondence illustrates, there was concern with the antitrust problems that would be generated by an agreement between Blue Shield and retail pharmacies, the effect of which would be to fix prices in the retail pharmaceutical industry. It was suggested that the price fixing agreement with pharmacies be camouflaged under the guise that it was a "mass accounting agreement." It was further suggested that Blue Shield might avoid federal antitrust scrutiny by drafting the price fixing agreement in such manner that it would have to be filed with the State Board of Insurance — thereby creating the illusion that it was part of the business of insurance regulated by the State Board.

> I think it would be best to draft the contract so that the Insurance Board would require filing of the mass accounting agreement [The Pharmacy Agrement] *to strengthen your base on antitrust*. Drafting problems will get sticky here, but let's pass on that for now. (Johnson Depo. Exhibit 32, App. 276a-277a, Add. 1) (emphasis added).

From the very beginning, Blue Shield has known that its price fixing activities are outside the business of insurance and subject to antitrust scrutiny.

Despite Blue Shield's machinations and its atempts to manipulate the McCarran Act to its advantage, the State Board of Insurance has left little doubt it does not consider The Pharmacy Agreement and its attendant price fixing to be a part of the business of insurance and that it does not consider The Pharmacy Agreement to be within its juris-

diction. Contrary to the representations on page 7 of Petitioners' brief, the State Board of Insurance did not disapprove The Pharmacy Agreement in 1969. Order No. 29701 by the Commissioner of Insurance on June 18, 1969, while disapproving Blue Shield's Prescription Drug Insurance Policy, made absolutely no mention of The Pharmacy Agreement Blue Shield gratuitously submitted therewith, nor of the price fixing activity contemplated by The Pharmacy Agreement. (Pogue Depo. Exhibit 53, App. 365a-366a). In discussing the problems raised by Blue Shield's Prescription Drug Insurance Policy, the Order makes no mention of The Pharmacy Agreement's being within the ambit of TEX. INS. CODE ANN. art. 21.21.

There is no doubt regarding the reasons underlying the Commissioner's silence about The Pharmacy Agreement. As is demonstrated by the deposition testimony of A. W. Pogue, Division Manager, Policy Approval Division of the State Board of Insurance,[9] contracts between an insurance company and a pharmacy, such as The Pharmacy Agreement, *are not* subject to the authority or control of the State Board of Insurance. When he was asked whether the State Board has "any jurisdiction over independent pharmacists in the State of Texas", Mr. Pogue answered,

> That is outside of our regulatory control. To the best of my knowledge, I know of no statutory jurisdiction over a pharmacy." (Pogue Depo. at 53, App. 339a-340a).

He testified further that the State Board of Insurance does not in any manner regulate pharmaceutical operations. (Pogue Depo. at 58, App. 342a). When asked whether The Pharmacy Agreement (Pogue Depo. Exhibit 6, App. 348a-

[9] Pogue Depo. at 3-4, App. 319a.

351a) would be a document subject to the regulatory authority of the State Board of Insurance, Mr. Pogue stated unequivocally,

> I do not feel that a contract of that nature falls within the *jurisdiction* of the State Board of Insurance. (Pogue Depo. at 68) (emphasis added).

Along these same lines, the following exchange took place:

> Q: [By Mr. Pullen] If pharmacies should enter into contracts with insurance companies such as Blue Shield, in your opinion, is that contract subject to regulation by the State Board of Insurance?
>
> A: [By Mr. Pogue] In my personal opinion I do not feel that it is a contract that would require approval of the State Board of Insurance. (Pogue Depo. at 58-59, App. 343a).

The Pharmacy Agreement does not fall within the jurisdiction of the State Board of Insurance and does not require the Board's approval because it does not constitute the business of insurance. If the agreement did constitute the business of insurance, it would be within the jurisdiction of the State Board since, as Mr. Pogue testified,

> [t]he Legislature gives us [The State Board of Insurance] regulatory authority over anything that encompasses insurance in the State of Texas. (Pogue Depo. at 66, App. 345a). If there is an insurance function involved, then the State Board would be in a regulatory position on the case. (Pogue Depo. at 66, App. 346a).

Counsel for Blue Shield elicited the same response from Mr. Pogue concerning The Pharmacy Agreement.

> Q: [By Mr. Kaiser] If it were determined by the Commissioner of Insurance that a drug service contract

such as the one you have been looking at here this morning with a participating pharmacist did constitute the business of insurance, would the State Board of Insurance have regulatory authority then?

A: [By Mr. Pogue] If we deemed that the use of *any type contract* did constitute the business of insurance, then the State Board of Insurance would look at it from a regulatory — [Interrupted by counsel for Blue Shield at this point].

Q: [By Mr. Kaiser] Thank you. I have no further questions. (Pogue Depo. at 69, App. 347a) (emphasis added).

As is shown by Mr. Pogue's testimony, the State Board of Insurance does not consider The Pharmacy Agreement to encompass or constitute the business of insurance. As Mr. Pogue testified, The Pharmacy Agreement is deemed merely to "constitute a contract between an entity and a pharmacy for the furnishing of services." (Pogue Depo. at 54, App. 340a). There is nothing special about this relationship that would subject it to the jurisdiction of the Board of Insurance nor make it a part of the business of insurance. The agreement and conspiracy between Blue Shield and the Defendant pharmacy chains to fix the retail sales prices of pharmaceuticals is not a part of the business of insurance.

The only evidence in the record that even remotely contradicts the testimony of the present Director of the Policy Approval Division is the response by Paul D. Connor, a former employee of the State Board of Insurance,[10] to a convoluted question regarding the exemption of Blue Shield's Prescription Drug Insurance Policy form. In September,

[10] Mr. Connor currently is an attorney with a law firm that represents "fifty . . . or more" insurance companies. (Connor Depo. at 30-31, App. 406a-407a).

1969, the State Board of Insurance exempted the Prescription Drug Insurance Policy form (and only this form) from the approval requirements of TEX. INS. CODE ANN. art. 3.42. With regard to this exemption, the following exchange took place between counsel for Blue Shield and Mr. Connor:

Q. [By Mr. Kaiser] . . . Mr. Conner, at the time of the issuance of this Exemption Order that you are looking at right now, was it your opinion that this particular contract which is marked Deposition Exhibit 52 [the Prescription Drug Insurance Policy], along with the Participating Drug Pharmacy Agreement which Blue Shield proposed to issue, was it your opinion *that that* constituted the business of insurance?

A: [Mr. Conner] Yes. (Conner Depo. at 13, App. 394a) (emphasis added).

A possible conclusion to be drawn from this exchange is that Mr. Connor, unlike Mr. Pogue, considered The Pharmacy Agreement to be a part of the business of insurance. However, the naming of the Prescription Drug Insurance Policy and The Pharmacy Agreement in separate clauses, followed by the phrase "that that" rather than "that these", leaves the issue in doubt. It is entirely likely that Mr. Connor understood the phrase "that that" to refer only to the Prescription Drug Insurance Policy. This construction is highly probable when one notes that immediately prior to the above-mentioned exchange, Mr. Connor testified that he did not recall having had occasion to review The Pharmacy Agreement before drafting the exemption order and that he has "no recollection of reading the document [The Pharmacy Agreement]." (Connor Depo. at 12-13, App. 393a-394a).

The testimony of Mr. Connor is weak evidence indeed for the proposition that the State Board regards The Pharmacy

Agreement to be part of the business of insurance.[11] Against this construction is the unambiguous testimony of the present Division Manager of the Policy Approval Division of the State Board of Insurance.

Blue Shield's own conduct demonstrates it is not serious when it alleges that The Pharmacy Agreement is within the jurisdiction of the State Board of Insurance. When Blue Shield desired to implement prescription drug insurance coverage in Bexar County, Texas in 1974, it submitted to *Mr. A. W. Pogue* of the State Board of Insurance (the individual whose deposition testimony Blue Shield wishes this court to ignore!) various documents *for approval.* (Pogue Depo. Exhibits 57 and 59, App. 374a-384a). Significantly, Blue Shield did not bother to submit The Pharmacy Agreement *for approval* with these documents, and the Commissioner's subsequent Order No. 45511 made no mention of The Pharmacy Agreement. (Pogue Depo. Exhibit 61, App. 385a-386a).

If Article 3.42 requires that The Pharmacy Agreement be submitted for approval as Blue Shield contends, then why was the document not submitted "for approval" in 1974? Blue Shield did not to submit The Pharmacy Agreement in 1974 because it knew the document is not within the jurisdiction of the State Board of Insurance and its filing is not required by article 3.42 of the Insurance Code.

Blue Shield desires to create the impression that the Attorney General of the State of Texas has scrutinized The

[11] Yet based on this testimony, Petitioners made the following unqualified assertion:

> The former Deputy Commissioner of the State Board testified in this case that Blue Shield's drug policy *and Pharmacy Agreement* constitute the business of insurance, and are subject to the full regulation, control and supervision of the State Board. (Brief for Petitioners at 32) (emphasis added).

Pharmacy Agreement for possible antitrust violations by asserting that after the Commissioner of Insurance issued Order No. 29701 disapproving the Prescription Drug Insurance Policy form, "[t]he policies *and Pharmacy Agreements* here in issue were referred by the State Board, after its review, to the Texas Attorney General for consideration under the state antitrust statutes." (Brief for Petitioners at 34, n. 30.) (emphasis added). In truth, the Board did not provide the Attorney General with a copy of The Pharmacy agreement as contended by Petitioners. Rather, as demonstrated by the Commissioner's transmittal letter to the Attorney General (Pogue Depo. Exhibit 54, App. 367a-369a), the Commissioner provided the Attorney General with a copy of the Prescription Drug Insurance policy, "Form CC-OHDS-2", and *not* a copy of The Pharmacy Agreement, "Form PDPA-1". The Commissioner did not mention Blue Shield's price fixing activities either.

In its efforts to convey the impression that the activities challenged by Respondents are considered by Texas to be a part of the business of insurance, Blue Shield makes several plays on words. In this connection, Respondents direct the Court's attention to Blue Shield's use of the term "program". Use of this term is a ploy by Blue Shield to create the impression that the Commissioner of Insurance and the Attorney General of the State of Texas have somehow determined that Blue Shield's challenged activities constitute the "business of insurance" and have been "aggressively regulated" as such. Blue Shield uses the nebulous term "program" to imply that all of its activities, including those challenged herein, were studied, considered, approved, or regulated by the various State officials or agencies discussed. This is incorrect. Each time Blue Shield uses the term "program", this Court must determine exactly what

activity(ies), contract(s), policy(ies), or document(s) actually were being studied, considered, approved, authorized, or regulated by the particular State official or agency in question. In no instance where the nebulous term "program" is used was The Pharmacy Agreement and its attendant price fixing approved, regulated, authorized or in any manner treated as a part of the business of insurance in Texas.

A graphic example of this misleading use of the term "program" is seen on page 34 of the Petitioners' brief. The assertion is there made that "the proposed insurance *program* remained under consideration by the State Board and the Commissioner subsequently authorized the *program.*" (Brief for Petitioners at 34) (emphasis added). This statement is entirely false, lacks support in the record, and directly contradicts the testimony of Mr. A. W. Pogue insofar as it suggests The Pharmacy Agreemest and its attendant price fixing were "authorized." It is curious indeed that Blue Shield can claim the State Board of Insurance has "authorized" that which is not even within the Board's *jurisdiction* according to the Director of the Policy Approval Division.

As Director of the Policy Approval Division of the State Board of Insurance, Mr. Pogue is the official charged with reviewing the documents within the Board's jurisdiction "to make sure that they comply with statutory requirements as set forth in the Insurance Code or that they comply with rules and regulations promulgated by the Board or by the Commissioner" (Pogue Depo. at 13, App. 324a-325a). Mr. Pogue's testimony set forth above shows The Pharmacy Agreement is not within the jurisdiction of the State Board of Insurance and that it neither requires nor is subject to the Board's approval or authorization. It is

shocking that Blue Shield continually makes the unsupported assertion that it has been entering into Pharmacy Agreements with Participating Pharmacies pursuant to the Commissioner's authorization. If such authorization had been given, Mr. Pogue would have been the first to know of it!

In claiming that its "program" has been "authorized" by the State Board of Insurance, Blue Shield is being more subtle than it was in its brief before the Fifth Circuit where it alleged the following:

> [Since October 1, 1974] Blue Shield has been . . . entering into Pharmacy Agreements with Participating Pharmacies pursuant to the *approval* granted by the Commissioner [of Insurance]. (Brief of Appellee Group Life and Health Insurance Company at 26) (emphasis added).

Apparently, Blue Shield has been motivated to utilize innuendo rather than outright statements by the knowledge that this Court will review the record as did the Fifth Circuit and reach the same conclusion as the latter.

> It is clear from the record that the Board has never approved the Pharmacy Agreement, and the Division Manager of the Board's Policy Approval Division, a Mr. Pogue, testified that he thought the Pharmacy Agreement was outside the State's regulatory control. (App. 133a)

It is difficult to conceive how a State agency can "authorize" that which is outside its jurisdiction and regulatory control. No amount of semantic manipulations can get around the unambiguous testimony of Mr. Pogue on this subject.

Q: [By Mr. Pullen] To your knowledge, has the State Board of Insurance ever approved Deposition Exhibit 6 [The Pharmacy Agrement] or any similar document?

A: To my knowledge, no, we have not.
[Pogue Depo. at 55, App. 341a).

Q: [By Mr. Pullen] Well, so that the record will be clear, is it your understanding that the State Board of Insurance under the regulatory authority granted it under the Texas Insurance Code has authority to regulate contracts between a company such as Blue Shield and an independent Pharmacy?

A: My own personal opinion is that this particular contract that you just showed me —

Q: [By Mr. Pullen] You are talking about Deposition Exhibit 6 [The Pharmacy Agreement]?

A: Right. Would be a contract between an entity and a provider *which would not be a part of the original or full contract of insurance.* The contract would be filed with us for informational purposes which would be part of a plan of operations, but when we get an entire plan of operations in, there are certain aspects of it that we file [such as The Pharmacy Agreement], certain aspects of it that we approve. (Pogue Depo. at 56, App. 341a-341a) (emphasis added).

Q: [By Mr. Pullen] If pharmacies should enter into contracts with Insurance companies such as Blue Shield, in your opinion, is that contract subject to regulation by the State Board of Insurance?

A: In my opinion I do not feel that it is a contract that would require approval of the State Board of Insurance. (Pogue Depo. at 58-59, App. 343a).

The Commissioner's Order No. 45511, dated October 1, 1974, while approving the Prescription Drug Insurance Policy form, "Form MF-1-DS-1", makes absolutely no mention of The Pharmacy Agreement (Pogue Depo. Exhibit 61, App. 385a-386a). The latter document was neither "approved" nor "authorized" in that or in any other order emanating from the Commissioner's office. The Pharmacy Agreement and its attendant price fixing are not considered by the Board to be a part of the business of insurance in Texas.

Only one order from the State Board of Insurance even mentions The Pharmacy Agreement, and that order does so in a peripheral manner that could in no sense be deemed an "authorization." Order No. 30413, dated September 30, 1969 (Pogue Depo. Exhibit 55, App. 370a-371a), exempts Blue Shield's Prescription Drug Insurance Policy form from the approval requirements of TEX. INS. CODE ANN. art. 3.42, but does not exempt The Pharmacy Agreement from anything nor in any manner "authorize" use of The Pharmacy Agreement. The exemption order provides in pertinent part as follows:

> "Pursuant to the authority granted by Article 3.42, Paragraph (e) of the Texas Insurance Code, the Commissioner of Insurance hereby exempts from the requirements of said Article *Policy Form CC-OHDS-2* [the Prescription Drug Insurance Policy form]. . . . This exemption order shall also apply to any form, *identical in content to Form CC-OHDS-2*, delivered, issued or used in this state by any licensed insurer [which would not include the Pharmacy Agreement, form PDPA-1.] . . . The *exempt forms* are described as *drug service contracts*, which confer upon the policyholder the right to obtain certain prescribed drugs at a cost [the deductible] fixed in the contract, the insurer having entered into participating agreements with dispensing pharmacies to supply the prescribed drugs to its policyholders. (Emphasis added).

Obviously, the Order merely "authorizes" use of the prescription Drug Insurance Policy form. Its sole reference to The Pharmacy Agreement is worded in such manner as to illustrate the Commissioner's feeling that The Pharmacy Agreement is outside his authority:

> ". . . the insurer *having entered* into participating agreements with dispensing pharmacies . . . (Emphasis added).

"Pervasive regulation" of The Pharmacy Agreement, its attendant price fixing, and the conspiracy to effect a boycott by Blue Shield's subscribers of the non-signing pharmacies is an illusion with no basis in fact.

Another example of Blue Shield's misleading use of the term "program" is seen on page 31 of Petitioners' brief, where the following allegation is made:

> [W]ith regard to a prepaid prescription drug program *identical* in concept and operation to the Blue Shield plan, the Attorney General concluded that the insurer "would be engaging in the business of insurance, in furnishing the prescription service required by its service agreements and pharmacy contracts." (Brief for Petitioners at 31) (emphasis added).

Blue Shield would have this Court believe that activities identical to those challenged herein by Respondents were reviewed in 1962 by the Texas Attorney General and determined at that time to be the "business of insurance." Such a determination was not made!

A copy of the ruling to which Blue Shield refers, Attorney General's Opinion No. WW-1475, dated December 11, 1962, is set forth at pages 473a-482a of the Appendix. As a close reading of the Attorney General's opinion clearly demonstrates, the "program" considered by the Attorney General

not only is *not* "identical" in concept and operation to the activities challenged by Respondents herein, but *was not* considered by the Attorney General for the purpose of determining whether *each* of the activities embraced by the "program" constituted the "business of insurance."

In the "program" submitted to the Attorney General, the contracts between the insurance company and the pharmacies did not fix the pharmacies' retail sales prices. Rather, the contracts set forth the *amount that the insurer was obligated to pay*, based on a schedule of prices as provided for in the contract, and provided that the policyholder would pay the remaining one-third or one-half (the fraction as specified in the contract) of the pharmacist's "prescription selling price", *which price was not set by agreement*. (App. 476a). The pharmacist's retail selling price, on which the policyholder's payment was to be computed, was not agreed upon in the provider agreement. In the "program" before the Attorney General, the Pharmacy Contract was merely an administrative agreement setting forth the pharmacies' obligation to dispense drugs to policyholders, the mechanics for reimbursement of the pharmacies, and the insurer's obligations.

Blue Shield's "program", however, fixes prices. The *total amount* of the pharmacies' retail sales prices are fixed by Blue Shield's Pharmacy Agreement, not merely the amount that Blue Shield is obligated to pay as was the case in the "program" before the Attorney General. By no stretch of the imagination is Blue Shield's "program" "identical" in concept and operation to that before the Attorney General in 1962.

Additionally, it must be stressed that the Attorney General did not state all of the activities involved in the 1962

"program" constituted the business of insurance, as Blue Shield suggests. The Attorney General was merely determining whether a particular corporation would, under the facts presented, be considered an insurance company; *not* whether each individual activity contemplated by that corporation constituted or was a part of the business of insurance. There is a crucial distinction between these two determinations. With respect to the former, it can be determined that a particular corporation is conducting business as an insurance company despite the fact that some of its myriad actions are peripheral to, and not a part of, the business of insurance. As this Court has emphasized, "[i]nsurance companies may do many things which are [peripheral to the business of insurance and hence] subject to paramount federal regulation." *S.E.C. vs. National Securities, Inc.*, 393 U.S. 453, 460 (1960). In his 1962 opinion, the Attorney General was not engaged in the task of determining which of Prepaid Prescription Plan, Inc.'s activities were a part of the business of insurance and which were not.[12]

An examination of the Attorney General's legal analysis and of the cases cited therein leaves no doubt concerning the narrowness of his inquiry. The Attorney General emphasized such narrowness with the following observation:

> As pointed out in your opinion request, the prescription selling price upon which the subscriber's payment is computed may be different from the price upon which the corporation's payment is computed. *This, however, is not material to the question presented.* (App. 477a n.1) (emphasis added).

[12] The Attorney General restated the question that was the subject of his inquiry. "You have asked our opinion as to whether or not the business proposed to be conducted by Prepaid Prescription Plan, Inc., is an insurance business." (App. 474a).

The question to be answered was whether Prescription Plan, Inc. would be conducting a Kaiser-type plan — in which a company provides services for a fee, employs entities to provide these services, and assumes no risk — or would be acting as a true insurance company. The Attorney General merely determined that, under the facts presented, a certain corporation would be considered an insurance company for the purposes of the Texas Insurance Code. *See*, App. 476a. This determination bears absolutely no logical relevance to the question whether the activities challenged in this case constitute the business of insurance.

The question here is whether Blue Shield's challenged *activities* constitute the business of insurance. The Attorney General's opinion provides absolutely no guidance on this point.

C. The Complaint and the Decisions Below

Petitioners erroneously attribute to Respondents the following contention:

> [T]hat in contracting with pharmacies to provide *policy* benefits to its insureds, Blue Shield was not engaged in the "business of insurance" within the meaning of the McCarran Act. (Brief for Petitioners at 9) (emphasis added).

This erroneous characterization of Respondents' claims is perpetuated throughout Petitioner's brief as a general attack on contracts between insurance companies and providers. Respondents are not attacking contracts between insurers and providers in general and are not alleging that all such contracts are outside the business of insurance.

Nor are Respondents attacking the mere fact that Blue Shield has entered into agreemcnts with pharmacies, which

agreements require the pharmacies to dispense pharmaceuticals to Blue Shield's policyholders and to look to the policyholders for direct payment of only a $2.00 drug deductible. If this were all that the Pharmacy Agreements provided, Respondents would have no complaint concerning them, and it would be true that The Pharmacy Agreements merely required the performance of obligations owed to the insureds and nothing more. However, The Pharmacy Agreements do more than merely obligate the Participating Pharmacies to dispense pharmaceuticals to Blue Shield's insureds and to look to the insureds for only $2.00 of the retail sales price. The Pharmacy Agreements go beyond this innocuous function and serve as a vehicle by which competing pharmacies conspire and agree concerning the *total price* that they will charge for dispensing pharmaceuticals to each of Blue Shield's policyholders. By virtue of The Pharmacy Agreements' price fixing provision, Blue Shield and the Petitioner Pharmacy chains are conspiring to eliminate competition in prices and services within the retail pharmaceutical industry. Contrary to Blue Shield's claims, it cannot be said that "the terms and provisions of the [prescription drug insurance] policies expressly contemplate the execution of such agreements." (Brief of Blue Shield at 17). The Prescription Drug Insurance Policy does not mention execution of agreements that serve to fix retail prices in the pharmaceutical industry.

Respondents contend that the McCarran Act does not provide a blanket exemption from the federal antitrust laws for *all* contracts between insurers and providers. When such contracts are utilized as vehicles to implement activities outside the ambit of the business of insurance, then to that extent they are subject to scrutiny under the federal antitrust laws. When an insurer combines and conspires with

retail pharmacy chains *to fix the latter's retail sales prices*, and employs a scheme of coercion to fix retail sales prices in the retail pharmacy industry generally, it has gone beyond the "business of insurance" and has stepped outside the McCarran Act's protective scope.

The Fifth Circuit followed this Court's ruling in *S.E.C. v. National Securities, Inc.*, 393 U.S. 453 (1969), and refused to grant blanket antitrust immunity for any and all activities embraced or implemented by contracts between insurers and providers of benefits. It followed the correct legal standard by analyzing the challenged activities to determine whether, absent their camouflage, they are a part of the "business of insurance," and noted that "[anticompetitive practices] do not become clothed with McCarran Act protection simply because an insurance company has contracted to pay the provider for goods or services." (App. 137a, 556 F.2d at 1386). The Fifth Circuit concluded "there is no . . . indication that the activities complained of are considered the business of insurance by the State or by any common sense interpretation of that term." (App. 135a, 556 F.2d at 1385).

SUMMARY OF ARGUMENTS

I. Petitioners' activities in conspiring and agreeing to fix the retail sales prices of pharmaceuticals, in conspiring to effect a boycott of pharmacists who refuse to agree on retail sales prices and in conspiring to foreclose pharmacists who refuse to agree on prices from a substantial portion of the market do not constitute the "business of insurance" in Texas and are not regulated as part of such business. The McCarran-Ferguson Act's (McCarran Act's) focus is on the relationship between the insurance company and the

insured. When the connection between challenged activities and this relationship is attenuated, as it is here, the challenged activity does not constitute the business of insurance. Since Petitioners' activities eliminate competition between retail pharmaciees with respect to prices and customer services, they primarily relate to the relationships between competing pharmacies and between such pharmacies and their customers. Any effects on the relationship between Blue Shield and its policyholders are merely peripheral and canot serve to invoke the McCarran Act.

The fixing of retail sales prices for pharmceuticals and the coercion of independent pharmacies to fix their prices are not obligations owed by Blue Shield to its policyholders under the Prescription Drug Insurance Policy. Blue Shield's sole obligation to each policyholder is to see that he is able to procure prescription drugs *at a cost to the policyholder* of only $2.00 per prescription (the drug deductible). Blue Shield utilizes price fixing to gain a degree of control over the magnitude of individual claims. Rather than control the maximum amount of individual claims through its contractual relationship with policyholders, Blue Shield has sought to control the dollar amount of individual claims by fixing the retail sales prices for pharmaceuticals in the pharmaceutical industry. By acting in this manner, Blue Shield has gone beyond the business of providing prescription drug insurance and has encroached on the business of selling prescription pharmaceuticals. The McCarran Act does not shield from antitrust scrutiny an insurance company's efforts to control the magnitude of its policyholders' claims through the elimination of competition in those industries providing goods and services for which benefits are payable under the insurance policy.

The McCarran Act does not give automatic antitrust immunity to every activity embraced or contemplated by a direct contractual relationship between an insurance company and providers of benefits that relates in some manner to the provision of benefits. Federal courts must look beyond labels and camouflage to see whether the particular activities constitute the business of insurance. Price fixing conspiracies between insurers and providers of benefits do not constitute the business of insurance and are not within the McCarran Act's protective scope. The McCarran Act does not apply *ipso facto* to every activity embraced or contemplated by a direct contractual relationship between an insurance company and a provider of benefits, which relates in some manner to the provision of benefits. Price-fixing agreements between insurers and the providers of benefits do not constitute the business of insurance and are not within the McCarran Act's protective scope.

The Texas State Department of Insurance does not consider The Pharmacy Agreement nor Petitioners' attendant price-fixing activities to encompass or constitute the business of insurance and has not undertaken to regulate the agreement or activities as a part of such business. When a State makes the determination that an activity does not constitute the business of insurance, and thereby serves notice that the activity will not be regulated as a part of business of insurance, as the Texas State Department of Insurance has done with respect to Blue Shield's Pharmacy Agreement, that determination should be controlling with the federal courts. A contrary holding by the federal courts violates the Supreme Court's mandate that the various exemptions from the antitrust laws are to be strictly construed.

II. Petitioners are pursuing a private system of wage-price controls with respect to the retail pharmaceutical industry. Texas does not regulate Petitioners' challenged activities as a part of the business of insurance. Congress did not intend that the McCarran Act be utilized to institute a system of *private regulation* by insurers and their co-conspirators, with mere tacit approval by the States. Since Petitioners' activities are conducted entirely without the safeguards of a State scheme of administrative supervision, they are subject to scrutiny under the federal antitrust laws.

III. The existence of boycott, coercion, and intimidation preclude the existence of McCarran Act immunity in this case. Section 3(b) of the McCarran Act dictates that an insurer's acts in coercing, intimidating, and effecting boycotts of independent retail pharmacists are removed from the Act's protective scope.

IV. The Petitioner pharmacy chains cannot invoke the McCarran Act to immunize their activities from antitrust scrutiny. When applicable, the McCarran Act only serves to exempt insurance companies and their agents or employees from federal regulation with respect to their activities constituting the business of insurance. Entities other than insurers, their agents, or their employees cannot engage in the "Business of insurance", and the McCarran Act does not insulate them from the federal antitrust laws merely because they may deal with insurers in some capacity.

Even if Blue Shield were able to immunize itself from the federal antitrust laws with respect to the activities challenged herein through reliance on the McCarran Act, the Petitioners pharmacy chains could be held accountable under the antitrust laws for their activities in combining and conspiring with Blue Shield and with each other.

Inability to maintain an antitrust suit against an insurance company for its activities constituting the business of insurance, due to the insurer's jurisdictional immunity for such activities, does not prevent maintenance of an antitrust action against a non-insurance company co-conspirator which does not, by definition, fall within the ambit of the McCarran Act.

ARGUMENT

I.

PETITIONERS ACTIVITIES IN COMBINING AND CONSPIRING TO FIX THE RETAIL SALES PRICES OF PHARMACEUTICALS, IN CONSPIRING TO EFFECT A BOYCOTT OF PHARMACY OWNERS WHO REFUSE TO FIX PRICES, AND IN CONSPIRING TO FORECLOSE PHARMACY OWNERS WHO REFUSE TO FIX PRICES FROM A SUBSTANTIAL PORTION OF THE MARKET DO NOT CONSTITUTE THE "BUSINESS OF INSURANCE" AND ARE NOT EXEMPTED FROM THE FEDERAL ANTITRUST LAWS BY THE McCARRAN-FERGUSON ACT.

A. The McCarran Act's Limited Immunity Only Applies To Activities That Constitute The "Business Of Insurance."

An appreciation of the McCarran Act's limited scope and applicability is essential a correct characterization of Petitioners' activities. The District Court's holding that the McCarran Act exempts Petitioners' challenged activities from antitrust scrutiny expands the Act's coverage to immunize from antitrust scrutiny virtually all activities of insurance companies and of those entities with which they contract. The Fifth Circuit refused to allow the expansion of the Act that the District Court permitted.

Section 2(b) of the McCarran Act provides as follows:

> No Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the *business of insurance . . . unless such Act specifically relates to the business of insurance*: *Provided, That* . . . the Sherman act, . . . the Clayton Act, and the Federal Trade Commission Act, as amended, shall be applicable to the *business of insurance* to the extent that *such business* is not regulated by State law. 15 U.S.C. § 1012 (b) (1970) [emphasis added].

The Act immunizes insurance companies from scrutiny under the federal antitrust laws only with respect to activities that constitute the "business of insurance," and only to the extent such activities are "regulated by State law".

A three step analysis is necessary to determine whether an insurance company's challenged activities fall within the Act's exemption. *See, e.g., Battle v. Liberty National Life Ins. Co.*, 492 F.2d 39, 49 (5th Cir. 1974), *cert. den.*, 419 U.S. 1110 (1975); *Travelers Ins. Co. v. Blue Cross*, 481 F.2d 80, 82 (3d Cir.), *cert. den.*, 414 U.S. 1093 (1973). First, the Court must determine whether the *challenged activities* constitute the "business of insurance". Second, it must determine whether the activities in question are regulated by State law. Third, the Court must determine the presence or absence of boycott, coercion, or intimidation.[13] *See*, 15 U.S.C. § 1013(b) (1970).

These three inquiries are independent of one another. A negative finding for the first question obviates the necessity

[13] Since the Fifth Circuit determined that Petitioners' challenged activities do not constitute the business of insurance, it did not need to reach the second and third steps of the analysis.

for a determination with respect to the second and third questions, and precludes application of the McCarran Act. *See, e.g., S.E.C. v. National Securities, Inc.*, 393 U.S. 453 (1969); *S.E.C. v. Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1959); *American General Ins. Co. v. FTC*, 359 F. Supp. 887 (S.D. Tex. 1974), *aff'd*, 496 F.2d 197 (5th Cir. 1974). If the challenged activities do not constitute the "business of insurance", the McCarran Act is inapplicable despite the existence of State legislation proscribing or otherwise regulating them. As one Court recently noted,

> "Even though the Commonwealth [Virginia] may have legislation similar to the Sherman Act and the Clayton Act, the McCarran-Ferguson Act does not oust the Court of jurisdiction unless the activities complained of, though prohibited by State legislation, are . . . a part of the "business of insurance" as defined in *National Securities." American Family Life Assurance Co. v. Planned Marketing Associates, Inc.*, 389 F. Supp. 1141 (E.D. Va. 1974).

Accord, e.g., S.E.C. v. National Securities, Inc., 393 U.S. 453 (1969) (Court held that despite existence of an Arizona statute which regulated the challenged activity, the McCarran Act was nevertheless inapplicable due to the activity's not being the "business of insurance"); *S.E.C. v. Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1959) (holding that variable annuity contracts are not a part of the business of insurance despite the fact that District of Columbia and some states regulated them as a part of the business of insurance); *Center Ins. Agency v. Byers*, 1976-1 Trade Cases ¶ 60,940, at 69,122, 69,123 n.2 (N.D. Ill. June 10, 1976) (denying application of the McCarran Act despite the fact that the challenged acts were regulated by all states with which they came into contact).

Thus, a determination of what constitutes the "business of insurance" is of central importance to the act's application. Congress did not define the scope of "business of insurance" as used in the McCarran Act, and its has been necessary for the courts to determine which of the insurance companies' challenged activities the phrase encompasses. *S.E.C. v. National Securities, Inc.*, 393 U.S. 453 (1969).

In determining whether a challenged activity constitutes the "business of insurance", federal courts must remember that the McCarran act operates in derogation of the antitrust laws and is to be strictly construed. Very recently, the Court emphasized the continued viability of this principle by warning that the various statutes which, like the McCarran Act, constitute exceptions to application of the antitrust laws "are to be construed strictly". *Abbott Labs v. Portland Retail Druggists, Ass'n, Inc.*, 425 U.S. 1, (1976) (strictly construing the Nonprofit Institutions Act exception to the Robinson-Patman Act). *Accord, e.g., FMC v. Seatrain Lines, Inc.* 411 U.S. 726, 733 (1973); *Perkins v. Standard Oil Co.*, 395 U.S. 642, 646-47 (1969). The Court has served notice that the various antitrust statutes are remedial in nature and are to be liberally applied. Laxity in finding exemptions from the antitrust laws has been rebuked with the observation that "our cases have repeatedly established . . . a *heavy presumption against* implicit [antitrust] exemptions." *Abbott Labs v. Portland Retail Druggists Ass'n., Inc.*, 425 U.S. 1, (1976) (brackets in original, emphasis added), *quoting Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787 (1975).

The McCarran Act's legislative history demonstrates that Congress did not intend to create an expansive exception to the antitrust laws. The Act was to be limited in scope and strictly construed.

> It is not the intention of Congress in the enactment of this legislation to clothe the States with any power to regulate or tax the business of insurance beyond that which they had been held to possess prior to the decision of the United States Supreme Court in the Southeastern Underwriters Association case. . . . In other words, we give to the States no more powers than those they previously had, and we take none from them. 91 CONG. REC. 1442 (1945) (remarks of Senator McCarran).

Accord, State Bd. of Ins. v. Todd Shipyards Corp., 370 U.S. 403 (1962). Members of Congress expressed fears that the limited exception might be perverted to deprive non-insurance businesses of the protections afforded by the federal antitrust laws, and were assured by the draftsmen that the Act was to be limited in scope.

> [Senator Pepper] Mr. President, does that not necessarily mean that we would give to the several State legislatures power, the character and outlines of which we do not define, to determine whether a Federal law [the Sherman Act] enacted for the protection of all business and against all kinds of monopolies and restraints of trade shall be effective in the American Union?
>
> [Senator McCarran] The bill does not go that far. 91 CONG. REC. 1443 (1945) (Remarks of Senators Pepper and McCarran).

The bill was an attempt to vest the States with power to regulate and tax the "business of insurance" — and only such power.

In construing the scope of the phrase "business of insurance", as used in the McCarran Act, the Supreme Court

has given application to these principles of strict construction and has emphasized the Act's limited scope. It has warned that merely because challenged conduct has been engaged in by an insurance company does not dictate its characterization as the "business of insurance."

> The statute did not purport to make the States supreme in regulating all the activities of insurance *companies;* its language refers not to the persons or companies who are subject to state regulation, but to laws "regulating the *business* of insurance." Insurance companies may do many things which are subject to paramount federal regulations; only when they are engaged in the "business of insurance" does the statue apply." *S.E.C. vs. National Securities, Inc.* 393 U.S. 453, 459-60 (1969) [emphasis in original].

Clearly, the Court wished to emphasize that a defendant's identity as an insurance company does not *ipso facto* clothe it with federal antitrust immunity with respect to all its activities.

The question to be determined by the Court, then, is whether the particular activities complained of, *even though they may be actions taken by an insurance company*, are part of the "business of insurance" that Congress sought to remove from federal regulation. If the challenged activities do not constitute the business of insurance, and are thus without the Act's protective umbrella, the defendant is subject to the full force of the antitrust laws regardless of its identity as an insurance company. *See, e.g., DeVoto v. Pacific Fidelity Life Ins. Co.*, 516 F.2d 1, 3 (9th Cir. 1975) (expressly approving District Court's ruling that McCarran Act was inapplicable to an insurer's activity in conspiring with a mortgage banker to foreclose another insurer from a segment of California market for

mortgage protection insurance); *Allied Financial Services, Inc. v. Foremost Ins. Co.*, 418 F. Supp. 157 (D. Neb. 1976) (holding that insurer's interference with general agent's contractual relations only peripherally involved business of insurance and were not entitled to McCarran Act protection); *American Family Life Assurance Co. v. Planned Marketing Associates, Inc.*, 389 F. Supp. 1141 (E.D. Va. 1974) (holding McCarran Act inapplicable to insurance company's activity in inducing plaintiff's agents to cease selling plaintiff's insurance and, instead, to sell defendant's policies); *Hill v. National Auto Glass Co.* 293 F. Supp. 295 (N.D. Calif. 1968) (holding McCarran Act exemption inapplicable to the activity of Allstate Insurance Co. in securing for various glass dealers the sales and installation jobs required by Allstate's claimants).

In subtly arguing for a broad construction of the McCarran act, Petitioners avoid any mention of the Supreme Court's decision in *Abbott Labs.* Petitioners have purposely avoided mention of *Abbott Labs* and its warning that the various statutory exemptions from the antitrust laws are to be strictly construed because the McCarran act can be found applicable to the challenged conduct in this case only through the most expansive construction of the act imaginable. Petitioners would have this Court conclude that any conspiracy between an insurance company and a provider of benefits that increases the insurer's profits or reduces its costs is shielded from the proscriptions of the antitrust laws by the McCarran Act. Just as the Court in *Abbott Labs.* rejected several drug manufacturer's expansive reading of the Nonprofit Institutions Act exception to the Robinson-Patman Act, the Court should reject Petitioners' expansive reading of the McCarran Act.

B. Activities That Primarily Affect The Relationships Between Competing Providers Of Benefits Or Between Competing Providers of Benefits And Their Customers, As Do The Challenged Activities Of Petitioners, Are Not The Business Of Insurance.

1. The McCarran Act's Focus Is on the Relationship Between The Insurer And The Insured.

In *S.E.C. v. National Securities, Inc.*, 393 U.S. 453 (1969), the Court articulated guidelines for ascertaining which activities of an insurance company constitute the "business of insurance" within the McCarran Act. It noted as follows:

> The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation and enforcement — these were the core of the "business of insurance". Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was — it was on the relationship between the insurance company and the policyholder. *Id.* at 459-60.

The Court applied this standard in *National Securities, Inc.* to deny that the merger of two insurance companies constituted the business of insurance, and thereby further refined the test. It is stressed that central to the determination is the question how closely the challenged activity concerns the relationship between the insurance company and the policyholder. If the connection between the challenged activity and this relationship it attenuated, and the insurer has gone beyond its function of underwriting a risk for a premium, the activity will not be considered to constitute the business of insurance. *Accord, e.g., Allied Financial Services, Inc. v. Foremost Ins. Co.*, 418 F. Supp. 157, 161

(D. Neb. 1976) (holding McCarran Act inapplicable where insurer's interference with general agent's contractual relations primarily related to agency agreement and not policyholders); *American Family Life Assurance Co. v. Planned Marketing Associates, Inc.*, 389 F. Supp 1141, 1147 (E.D. Va. 1974) (holding McCarran Act inapplicable where the relationship affected by the challenged activity was primarily that between two insurers and not that between the insurers and their policyholders). The mere fact that the challenged activity may have some slight effect on the insurance company's reliability, its solvency, or its ratemaking is insufficient. Virtually every business activity by an insurer will have some effect, however slight, on these parameters. It is the relationship primarily affected by the challenged activity that is crucial.

In *National Securities, Inc.*, the Court held that the activity of two insurance companies in merging did not constitute the business of insurance, despite the fact that the transaction undoubtedly affected policyholders in terms of the security of their insurance contracts and the reliability of their insurers. Central to the Court's decision that the insurers' merger activity was without McCarran Act protection, despite the possible effects on policyholders, was its determination that the "business of insurance" pertained to those activities *peculiar* to the insurance industry. Business activities of insurance companies not peculiar to their function as insurers, even though they were bound to affect policyholders, were held by the Court to be outside the McCarran Act and subject to federal regulatory laws. *Accord, e.g., Center Ins. Agency, Inc. vs. Byers*, 1976-1 Trade Cases ¶60,940, at 69,122 (N.D. Ill. June 10, 1976); *American Family Life Assurance co. vs. Planned Marketing Associates, Inc.*, 389 F. Supp. 1141 (E.D. Va. 1974); *Ameri-*

can General Ins. Co. vs. FTC, 359 F. Supp. 887 (S.D. Tex. 1973), *aff'd*, 496 F.2d 197 (5th Cir. 1974).

2. Thie Challenged Activities Primarily Relate The Relationships Between Competing Pharmacies And To The Relationships Between Competing Pharmacies And Their Customers.

The activities challenged herein, like that before the Court in *National Securities, Inc.*, relate primarily to relationships other than that between the insurer and its policyholders and are not peculiar to the insurance industry. Any effects on the relationship between Blue Shield and its policyholders are merely peripheral and are secondary to the effects on the relationships between competing pharmacies and between such pharmacies and their customers. The policy here does not include the fixing of the pharmacist's retail price as a "benefit" to the insured.

The relationship between competing pharmacies is affected because the fixing of retail sales prices eliminates competition between pharmacies in pricing and in the provision of the customer services. As the number of individuals covered by Blue Shield's prescription drug insurance increases, which the record shows it has been doing at a dramatic rate, the elimination of competition between pharmacies will become all the more complete. The large pharmacy chains who sell many items in addition to pharmaceuticals, whose customer services are limited, and who can afford to operate under the agreement, will be enabled to eliminate the small independent neighborhood pharmacies whose existence depends primarily on profits derived from the sale of prescription drugs.

That the relationship primarily affected by the price fixing agreement and the coercion is that between competing

pharmacies is graphically illustrated by examining the effects that the challenged activities would have on other sectors of our private economy. If the activities as challenged herein are held to constitute the business of insurance, then automobile insurers will be able to utilize Participating Repair Shop Agreements and Coercion to set prices for parts and labor in the automobile repair industry. Since third party payments cover a large percentage of the automobile repair work currently performed, the insurance companies would be able to combine and conspire with the large repair shops to set prices for parts and labor. The small independents would be squeezed out of business.

The coverage provided by insurance companies in our modern society is so pervasive that examples of "Participating Agreements" between insurers and the providers of services would be limited only by the bounds of human ingenuity. Companies that write fire insurance would be able to execute "Participating Construction Company Agreements" and thereby combine and conspire with large construction companies to set the prices for the repair and rebuilding of homes or buildings damaged by fire. They would also be able to execute Participating Agreements with large department stores and thereby endeavor to set prices at which insureds would replace televisions, stereos, furniture, clothing and other articles destroyed by fire. Hardly, a sector of our economy would be free from the price fixing activities of insurance companies if the activities as challenged herein are immune from the federal antitrust laws. Insurers and the large "providers" would be given *carte blanche* to determine the prices to be charged in each industry that happens to sell goods which are purchased with the proceeds of insurance policies. These entities would be free to determine whether and what forms of competition

are to be allowed, as well as which competitors would be allowed to exist.

Indeed, if the challenged activities are allowed under the guise that they constitute the business of insurance, they could be utilized to eliminate competition among many other entities in addition to those providing goods and services directly to the insurer's policyholders. For example, if Blue Shield is allowed to combine and conspire with pharmacies to fix the retail sales prices of pharmaceuticals, nothing prevents Blue Shield's combining and conspiring with pharmaceutical manufacturers to fix the wholesale prices of pharmaceuticals. Blue Shield could enter into Participating Drug Manufacturer Agreements with various manufacturers of penicillin, which would require the manufacturers to sell penicillin to Blue Shield's Participating Pharmacies at or below the price stipulated in the agreement. If a small manufacturer refused to sign the price fixing agreement, Blue Shield could exert pressure by refusing to provide its policyholders with coverage for that manufacturer's brand of penicillin, or by providing markedly reduced benefits when that brand was purchased. If the small manufacturer depended heavily on sales of antibiotics to stay in business, and if the price agreed on by Blue Shield and the large, diversified manufacturers was too low for the small manufacturer to make an adequate return, it would be pushed out of business. Certainly Congress never intended that the McCarran act be utilized to shield such activity from application of the federal regulatory laws. Although Congress, in enacting the Act, wished to authorize state-supervised rate setting, it was as opposed to private price-fixing as ever and did not intend that such activity be shielded from federal scrutiny by the McCarran Act. *See*, in particular, comments by Senator O'Mahoney, a co-

sponsor of the bill in 91 CONG. REC. 1480, 1483, 1485-86 (1945).

C. Insurance "Jargon" and "Catch" Phrases" Cannot Be A Substitute For Careful Analysis When A Court Decides Whether Challenged Activities Constitute The Business Of Insurance.

When the Court articulated guidelines for determining which activities of insurers constitute "the business of insurance," it emphasized that the term's focus was on the "relationship between the insurance company and the policyholder." *See S.E.C. vs. National Securities, Inc.*, 393 U. S. 453, 459-60 (1969). Additionally, the Court stated that at the core of the "business of insurance" was "the type of policy which could be issued, its reliability, interpretation and enforcement." *Id.* Other activities of insurance companies were said to be included provided "they relate so closely to their status as reliable insurers" as to require inclusion. *Id.*

These standards articulated by the Court can serve as a basis for analysis, as the Court undoubtedly intended, or they can be utilized as catch phrases to describe virtually any activity undertaken by an insurer. Unfortunately, an insurance "jargon" has arisen in McCarran Act cases, and defendants have converted the Court's guidelines to mechanical word formulae, which routinely are utilized to describe their challenged activities.

Petitioners do not discuss the activities challenged by Respondents. Rather, they choose to talk about innocuous contracts "between an insurer and a health care provider *to furnish benefits owed to policyholders under the insurer's health care policies.*" (Brief for Petitioners at 16) (emphasis added). They label these innocuous contracts as "provider

agreements," state that they have been around since at least the 1930's, and allege that The Pharmacy Agreement is just another old and familiar "provider agreement." Brief for Petitioners at 20-27. Then Petitioners proceed to utilize the Court's guidelines as a form of insurance "jargon" to describe The Pharmacy Agreement. *See* Brief for Petitioners at 20-31.

A close perusal of the Prescription Drug Insurance Policy (McDonald Depo. Exhibits 37 and 39, App. 303a-318a) demonstrates that the fixing of retail sales prices for pharmaceuticals and the coercion of pharmacies to fix their prices *are not* "benefits owed to policyholders under the insurer's health care policies." Indeed, Blue Shield's sole obligation is to see that *the insured* receives prescription drugs and "*shall be required to pay no more* than the drug deductible for each of such covered drugs." The policy describes providers as participating or non participating based only on whether they have agreed to furnish covered drugs. Price is not mentioned. It is not relevant to the policyholder that Blue Shield conspires with pharmacies to fix retail sales prices in the pharmacy industry.

As Blue Shield's Assistant Vice-President in charge of enrolling "Participating Pharmacies" testified, the Pharmacy Contract merely is a contract between Blue Shield and the pharmacy, which the policyholder never sees (Johnson Depo. at 34, App. 151a). The policyholder is obligated to pay a participating pharmacy $2.00 for his prescription regardless of the presence or absence of price fixing. The conspiracy to fix prices is merely a profit-maximizing endeavor for Blue Shield's benefit, as the merger activity of two insurance companies in *S.E.C. v. National Securities, Inc.*, 393 U. S. 453 (1969), was an activity for the financial

benefit of the two insurers, which activity was held to be peripheral to the business of insurance.

Blue Shield is no more obligated to its policyholders to fix the retail sales prices of pharmaceuticals than an automobile insurer is obligated to its insureds having $100 deductible policies to fix the prices charged by body shops for parts and labor. Just as the automobile insurer is obligated to pay the retail cost of repair, whatever it might be, over and above the applicable policy deductible, Blue Shield is obligated to pay the retail cost of prescription drugs over and above the $2.00 drug deductible. There is no obligation to fix prices! As the Prescription Drug Insurance Policy provides, "[p]ayment of benefits by Blue Shield of Texas to the provider or the employee . . . shall constitute full discharge of all responsibility of Blue Shield of Texas to the employees." (Article IIIC of McDonald Depo. Exhibit 39, App. 316a).

Further proof that the fixing of prices is not a "benefit" owed to policyholders" is afforded by Article VIB of the Prescription Drug Insurance Policy, which provides as follows:

> Blue Shield shall not be liable for any claim or demand for injuries or damages arising out of or in connection with the manufacturing, compounding, dispensing or use of any Prescription Legend Drug or insulin, whether or not covered under this supplement. (McDonald Depo. Exhibit 39, App. 318a)

By virtue of this paragraph, Blue Shield services notice that the sale of pharmaceuticals is a transaction between the pharmacy and the policyholders with respect to which Blue Shield assumes no responsibility *or obligation* other than that of underwriting the sale.

Petitioners make the ingenious argument that The Pharmacy Agreement merely allows Blue Shield to furnish benefits *owed* to policyholders under the insurer's health care policies, and nothing more, because "Blue Shield has agreed to furnish policy benefits to its insureds through providers of prescription drugs" and "the only way such benefits can be guaranteed is through contractual arrangements with pharmacies." (Brief for Petitioners at 13). Further, "[t]he failure to provide Participating Pharmacies which permit the insured to obtain drugs on the terms and for the amounts stated in the policies would constitute a breach of the contract of insurance." (Brief for Petitioners at 13-14). This argument is a red herring.

Respondents are not attacking the mere fact that Blue Shield has entered into agreements with pharmacies, which agreements require the pharmacies to dispense pharmaceuticals to Blue Shield's policyholders and to look to the policyholders for direct payment of only a $2.00 drug deductible. If this were all that the Pharmacy Agreements provided, Respondents would have no complaint concerning The Pharmacy Agreements; and it would be true that The Pharmacy Agreements merely required the performance of obligations owed to the insured and nothing more. However, The Pharmacy Agreements do more than merely obligate the Participating Pharmacies to dispense pharmaceuticals to Blue Shield's insureds in return for a direct payment by the insured of the $2.00 drug deductible. The Pharmacy Agreements go beyond this innocuous function and serve as a vehicle by which competing pharmacies conspire and agree concerning the *total price* that they will charge for dispensing pharmaceuticals to Blue Shield's policyholders. By virtue of The Pharmacy Agreements' price

fixing provision, Blue Shield and Petitioner Pharmacy chains are conspiring to eliminate price competition in the retail pharmaceutical industry. Contrary to their claims, it cannot be said that the terms and provisions of the prescription drug insurance policies expressly contemplate the execution of such agreements. The Prescription Drug Insurance Policy does not mention execution of agreements that serve to fix retail prices in the pharmaceutical industry.

Contrary to the impression that Blue Shield desires to create, this Court's striking down the price fixing aspects of The Pharmacy Agreements would not interfere with or preclude Blue Shield's providing its policyholders with Participating Pharmacies. Blue Shield would in no way be precluded from contracting with pharmacies to dispense pharmaceuticals to its policyholders in return for the policyholders' direct payment to the pharmacies of the $2.00 drug deductible. It is the latter agreement that is expressly contemplated by the Prescription Drug Insurance Policy, not an agreement that seeks to fix prices in the pharmaceutical industry. As has been discussed, the decision to embody the price fixing conspiracy within The Pharmacy Agreement was merely part of an elaborate scheme to shield such activity from antitrust scrutiny by virtue of the McCarran Act. See Johnson Depo. Exhibit 32, App. 276a-277a, Add. 1). The Court must not be misled by Blue Shield's scheme.

The Pharmacy Agreement is not just another old and familiar "provider agreement." Each Justice of this Court need only analyze his own experience with insurance policies down through the years to see the fallacy of the story Petitioners have woven. Can a single Justice recall having been told the following by his insurer upon the occurrence of an auto accident: "You need only pay the $100 deductible if you take the car to a "participating repair shop," but you

must pay 25% of a reasonable charge for repairs, as determined by us, in addition to the $100 deductible if you take the car to a "non-participating repair shop"?

Petitioners' efforts to convince the Court that their challenged activities have been around since the depression are internally inconsistent. On page 6 of Petitioners' brief, Blue Shield argues that its challenged activities had their roots in the 1967 collective bargaining agreement between the United Auto Workers, Ford, General Motors, and Chrysler. Indeed, the May 28, 1968, letter to Blue Shield's president, Johnson Depo. Exhibit 32 (App. 276a-277a) (Add. 1) marks the inception of Petitioners' challenged activities. In that letter, an officer of the National Association of Blue Shield plans communicated his "germ of an idea" for pursuing anticompetitive activities in the retail pharmaceutical industry in a manner that would "strengthen your [Blue Shield's] basis on antitrust." *Id.* What was being contemplated in the letter, and what arose from the letter, was not just another old and familiar "provider agreement."

At least the National Association of Insurance Commissioners (NAIC) has admitted in its amicus curiae brief that Petitioners' challenged activities as implemented by The Pharmacy Agreement are not holdovers from the great depression, but are a new "experiment" to "contain costs." *See* Amicus Curiae Brief of the National Association of Insurance Commissioners (NAIC Brief) at 37-43.

Petitioners' activities may indeed constitute an "experiment" for insurers, but the Court will recognize them, absent their "provider agreement" camouflage, as time-worn abuses of our free market economy practiced by entities with market power. A close scrutiny of this "experiment" in "cost containment" — a scrutiny that focuses on *whose* costs

are being "contained" and *why* — illustrates that the activities challenged by Respondents are peripheral to the business of insurance and, as far as Blue Shield is concerned, merely constitute an effort by Blue Shield to increase its profits at the expense of competition in another, non-insurance industry.

D. The "Experiment" In "Cost Containment" Is Not A Part Of The Business of Insurance.

1. It Is Not The Office Of The Insurance Industry To Set The Prices In The Various Sectors Of Our Economy So That Insurers Will Enjoy An Added Measure Of Control Over The Magnitude Of Individual Claims.

Petitioners cite *S.E.C. v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 73 (1959), for the proposition that the "earmark" of insurance is the 'underwriting of risks' in exchange for a premium." (Brief for Petitioners at 20). With respect to the Prescription Drug Insurance Policy, Petitioners allege the "risk" insured against is the following:

> the possibility that, during the term of the policy, *the insured may suffer a financial loss arising from the purchase of prescription drugs*, or that he may be financially unable to purchase such drugs. *Id.* (emphasis added).

Petitioners then claim that Blue Shield "assumes this risk," which, after all, is the essential function of an insurer — to assume all or a portion of a specified risk in return for payment of a premium.

Blue Shield claims to be "assuming the risk" by contracting with "Participating Pharmacies." *Id.* Herein lies the heart of the great fallacy Petitioners are trying to propagate. By conspiring with the Petitioner pharmacy chains to fix the retail sales prices for pharmaceuticals, and by pursuing

a course of conduct calculated to coerce independent pharmacies to agree on retail prices, Blue Shield is seeking to rid itself of the risk it would shoulder if it were truly functioning as an insurer engaged in the business of insurance — not assume the risk. Blue Shield is seeking to shift the expense and burden of the risk to the retail pharmaceutical industry. In pursuing these activities, Blue Shield is acting outside the business of insurance. A step by step analysis will illustrate this point.

An individual faces the possibility that he will need prescription drugs, but does not know how often he will need them or the price he will pay. He purchases insurance, prescription drug insurance, which basically provides that in exchange for the premium and after payment by him of a deductible each time, the balance of the cost will be paid by an insurer. Blue Shield, however, in limiting the pharmacist to the receipt of the deductible from the insured and the acquisition cost from Blue Shield, has taken a substantial portion of the risk it insures against and shifted it to the retail pharmacies which are *not* in the business of underwriting Blue Shield's risk. It is not necessary that Blue Shield fix prices in the retail pharmacy industry to have the control over its claims as it would have this Court believe is all that it is trying to do. Blue Shield is not the guardian of its customers' financial wellbeing, nor are the state insurance commissioners the guardian of the public pocket book in all respects. Indeed, they are insurance commissioners, not pharmacy commissioners, drug commissioners, automobile commissioners, home repair commissioners, furniture commissioners, or clothing commissioners. Their function basically is to see that benefits are fair and reasonable for the premium paid, and that companies have sufficient reserves to meet their obligations to their policy holders. Yet Blue Shield and the National Association of Insurance Commissioners claim that they are the only proper guardians of the prices charged in the various provider industries. They seek to "contain costs" at the expense of competition and use this case in actuality to attempt to take a limited exemption to the anti-trust laws, the McCarran Act, and expand it to cover virtually every contract that an insurance company may enter into with a provider of benefits.

They purport to justify their price fixing activities by use of the term "cost containment." However, every business, not just insurance companies, is concerned with containing their costs. Congress has determined that costs can best be contained by free and unfettered competition, and this strong, national policy has been evidenced in the federal anti-trust laws. This Court should not take the various competitive sectors of our economy and subject them to regulation by the state insurance commissioners and the insurers, but that is exactly what Petitioners and their amici ask this court to do in this case. Almost every other form of insurance allows the free market forces of competition to operate. The insurers may limit their risk in many ways in their contract with the insured — by limiting the number of claims per period of time, by limiting the dollar amount of benefits per claim, and by use of deductibles. Yet here what is attempted to be immunized from the federal anti-trust laws is an attempt to fix prices in non-insurance industries. If containing costs is the test, then the next step will be that insurance companies will "contain" providers' costs that are purely administrative and operational. Further, if this court reverses the Fifth Circuit's decision, insurers will be given *carte blanche* to violate the federal anti-trust laws with impunity. Indeed, if there were ever a case which shows the wisdom of Congress in passing the Sherman Act, and providing for the private federal anti-trust action, this case is it.

When it first contemplated fixing pharmacists' prices, Blue Shield knew it was invading a non-insurance sector of the economy. This is illustrated in the previously mentioned correspondence between the president of Blue Shield of Texas and an official of the National Association of Blue Shield Plans concerning the preparation of what was to become Blue Shield's Pharmacy Agreement. *See* Johnson Depo. Exhibit 32 (App. 276a-277a) (Add. 1). The letter expressly contemplates an agreement between Blue Shield and pharmacies, the effect of which would be to fix the latter's prices. It suggests that the price fixing agreement with pharmacies be camouflaged under the guise it is a "mass accounting agreement" and indicates Blue Shield might avoid antitrust scrutiny by drafting the price fixing agreement in such manner as to create the illusion it is part of the business of insurance regulated by the State Board of Insurance.

> "I think it would be best to draft the contract so that the Insurance Board would require filing of the mass accounting agreement [Pharmacy Agreement] to strengthen your base on anti-trust. Drafting problems will get sticky here, but let's pass on that for now."

(Johnson Dep. Exhibit 32, App. 277a, Add. 1). Despite the sugar-coating contemplated by the correspondents, the basic price-fixing function is clearly articulated.

> The mass accounting agreement [Pharmacy Agreement] probably should have self-serving whereas clauses emphasizing Blue Shield's intent to offer coverage, desire to relate payments to providers for these services, and the need to simplify administration and accounting in the public interest. The basic agreement would be that the accounting basis of indemnification under the facility of payment clause of the subscriber contract, for Blue Shield subscribers for

> services rendered by the pharmacy, would be acquisition cost plus dispensing fee in the aggregate for all services within a reporting period and that the pharmacy would make no charge to the subscriber in excess of the deductible."

Id. The correspondence leaves no doubt that the price-fixing and discrimination in benefits actually are not intended by the parties to relate to any "simplification in administration and accounting." They are intended to have their natural and probable effect — the fixing of prices in the pharmacy industry.

> "Tom, there are a lot of holes in this, but the alternative is paying usual and customary — *and praying*." *Id.* (emphasis added).

The alternatives to price fixing are Blue Shield's paying the individual pharmacists' usual and customary charge, as does the individual who shops on the open market without insurance, or Blue Shield's paying some fixed percentage or maximum dollar amount of the individual pharmacist's usual and customary charge, with the subscriber being responsible for the balance of such charge. These alternatives are pursued by traditional insurers, who engage in the business of insurance without conspiring to fix prices.

By fixing prices, Blue Shield has gone beyond the business of providing prescription drug insurance and has encroached on the business of selling prescription pharmaceuticals. It is not a part of the business of insurance for an insurer to use its market power to see that its insureds obtain the goods and services contemplated by the insurance policy on a "cost-plus" basis or any other basis that might be more economical for the insurer than the insured's retail purchase of such products on the open market. It is the

business of insurance for an insurer to underwrite risks, not to wield its massive economic power against other industries in an effort to control the retail prices charged by those industries.

By conspiring with pharmacies to fix retail sales prices in the pharmacy industry, Blue Shield has engaged in activities totally alien to the insurer-policyholder relationship, which is the focus of the McCarran Act. Such activity *clearly is not* the business of insurance! Its focus is not the insurer-policyholder relationship and it certainly is not peculiar to the insurance industry. Blue Shield suddenly argues that the "reliability" of its prescription drug insurance policies "is dependent upon Blue Shield's contracting with Participating Pharmacies for the benefit of its insureds." Brief for Petitioners at 27. To the extent that Blue Shield's "reliability" argument includes the price fixing aspects of The Pharmacy Agreement and Blue Shield's use of coercion to fix pharmaceutical prices generally, it is nothing more than an argument that any activity which will increase an insurer's profits affects the "reliability" of its insurance policies. Obviously, any activity that will increase an insurer's profit margin is calculated to make it and its policies more reliable in the sense that the company is less likely to go bankrupt. However, the Supreme Court has served notice that the mere fact that an activity will serve to make an insurer more financially stable, and hence more "reliable", does not dictate the activity's classification as part of the business of insurance. *See S.E.C. v. National Securities, Inc.*, 393 U.S. 453 (1969). In *National Securities, Inc.*, the Supreme Court held that the activity of insurance companies in merging did not constitute the business of insurance, despite the fact that the transaction undoubtedly directly affected the financial stability of the two companies,

which in turn affected policyholders in terms of the security of their insurance contracts and the reliability of their insurers. If activities' financial effects on insurance companies were utilized as the test whether the activities related directly to the insurers' status as reliable insurers, and thus were within the McCarran Act's protective scope, the Act would serve to shield virtually any activity of an insurer from antitrust scrutiny. *National Securities, Inc.* rejected this notion.

Petitioners endeavor to justify their "cost containment" by arguing that Blue Shield faces "indeterminate liability" under its prescription drug insurance policies. (Brief for Petitioners at 23). They explain further:

> Because illnesses vary in frequency, duration and severity, and because the prices of prescription drugs are subject to rapid inflation, no one knows in advance of the insured's illness what monetary obligation Blue Shield will be required to bear to satisfy his or her claim. *Id.*

This statement does nothing more than describe the risk that the individual contracts to shift to the insurer when he buys prescription drug insurance. Blue Shield's lack of desire to shoulder the risk does not convert to the "business of insurance" its efforts to shift the risk to the retail pharmaceutical industry. Congress did not contemplate that the McCarran Act be utilized to insulate such activities by insurers from the federal antitrust laws. As one Court recently observed,

> The roll of insurance in our complex commercial society is pervasive. Insurance companies with their policies, their agents and their customers touch and concern all commercial activity. The McCarran-Ferguson Act did not purport to make state legislation

> supreme in regulating all the activities of insurance *companies.* It does allow the states to regulate the *business* of insurance . . . but such business if not the subjct of this litigation." *DeVoto v. Pacific Fidelity Life Ins. Co.*, 354 F. Supp. 874 (N.D. Calif. 1973) [emphasis in original], *aff'd as to holding on McCarran Act, rev'd and remanded on other grounds*, 516 F.2d 1, 3 (9th Cir. 1975).

Such business likewise is not the subject of the present litigation!

2. The Supposed Public and Governmental Mandate To "Contain" Health Care Costs Does Not Make Petitioners' Challenged Activities The Business of Insurance.

Petitioners and especially their amici devote much attention to a discussion of spiralling HEALTH CARE COSTS. Time and again they refer to a huge escalation in HEALTH CARE COSTS and to Blue Shield's obligation to contain such costs. They even cite some statistics to show a dramatic increase in HEALTH CARE COSTS. But what about PRESCRIPTION PHARMACEUTICAL COSTS? Why have Petitioners and their amici avoided giving statistics for increases in PRESCRIPTION PHARMACEUTICAL COSTS when such statistics are readily available in the same sources that were consulted for HEALTH CARE COSTS, and when the costs Petitioners allegedly seek to "contain" herein are those for prescription pharmaceuticals?

Petitioners and their amici have carefully avoided a discussion of the rise in prescription pharmaceutical costs because they wish to give Petitioners' challenged activities a social credibility that does not really exist. They wish to establish the impression that there is a public and governmental mandate calling for Petitioners' price fixing activities.

Contrary to the impression Petitioners and their amici try to create, statistics compiled by the U. S. Department of Labor demonstrate that the retail prices of prescription pharmaceuticals have been dramatic for their small increases over the years — *not* for their rapid escalation as Petitioners and their amici infer by citing "health care" statistics.

In the period 1967-February, 1978, the prices for prescription pharmaceuticals increased *only 28.5%*, while the prices of amici Motor Vehicle Manufacturers' new cars increased 51.1% — almost twice as much! U. S. DEP'T. OF LABOR, BUREAU OF LABOR STATISTICS, CONSUMER PRICE INDEX DETAILED REPORT FEBRUARY, 1978 (CONSUMER PRICE INDEX) at 22-23 (1978). The small increase in prices for prescription pharmaceuticals is even more dramatic when one notes that over the same period, the average increase in prices for all items was 88.4% — slightly more than three times as much![14] CONSUMER PRICE INDEX at 13. In discussing "the rapidly escalating costs of health care," amici United Auto Workers not only fail to cite statistics for prescription pharmaceuticals, but fail to point out that over the period 1967-February, 1978, the salaries of individuals employed in the manufacture of transportation equipment increased 99.5% — almost four times as much as the increase in costs of prescription pharmaceuticals! U. S. DEP'T. OF LABOR, BUREAU OF LABOR STATISTICS, EMPLOYMENT AND EARNINGS MAY, 1978 at 99 (1978).

Where is the "crisis" in prescription pharmaceutical costs? There is much more of a "crisis" in the costs of automobiles

[14] At least it safely can be assumed that Blue Shield will not now make an about face and endeavor to take credit for the pharmaceutical industry's admirable performance in the area of price increases. The Blue Shield Association has alleged that Blue Shield plans underwrite only 2% of total retail drug sales. Amicus Curiae Brief of The Blue Shield Association at 33.

and the salaries of auto workers than there is in prescription pharmaceutical costs. The rising costs of hospital rooms in America, which is the basis for the statistics cited by Petitioners and their amici, cannot justify insurers' undertaking private regulation of other industries that happen to sell goods or services purchased in whole or in part with the proceeds of insurance.

Petitioners claim that their challenged activities are being conducted in response "to the urgings of government officials, employers and labor unions." Brief for Petitioners at 23. There is no indication of "urgings by government officials." In alleging such "urgings", Petitioners and their amici omit discussion of congressional recommendations that run directly counter to Petitioners' challenged activities. One such recommendation is the following:

> That the fee paid to pharmacists be flexible and vary according to the individual pharmacists' cost of doing business, and that he be given additional sums for the extra services he provides to assure that he is adequately compensated for his services, and to encourage the expansion of improved services which will benefit the consumer. SUBCOMMITTEE ON ENVIRONMENTAL PROBLEMS AFFECTING SMALL BUSINESS OF THE PERMANENT SELECT COMMITTEE ON SMALL BUSINESS, PROBLEMS OF THIRD PARTY PREPAID PRESCRIPTION PROGRAMS, H. R. DOC. NO. 93-730, 93d Cong., 1st Sess. 17 (1973) (*Problems of Third Party Prepaid Prescription Programs*).

In arguing against the very activities Petitioners and their amici claim are being conducted with a public and governmental mandate, this Congressional report stressed the dangers of the activities.

> Demographically, union members tend to concentrate in specific sections of a city. Businesses serving these concentrated areas are basically service businesses which are dependent upon continued union member patronage. Nonparticipation by a pharmacist serving such areas would discourage union member patronage and result in financial failure. Yet, because of the inflexibility in the method of determining his fee, participation in third party programs may also result in financial failure. Herein lies the essence of the pharmacist's dilemma. *Problems of Third Party Prepaid Prescription Programs* at 6.

The Congressional Report expressed additional concern, "that fixed fees provide no incentive to pharmacists to improve the quality of their services, and, thereby, might discourage improvements which increase the quality of this Nation's health care systems." *Problems of Third Party Prepaid Prescription Programs* at 10. This Congressional Report did *not* recommend that insurers take steps to "contain" pharmacists' prices. Rather, it expressed a concern with insurers' activities and recommended that the Department of Justice do the following:

> Undertake an investigation of the concentration of certain insurance companies and plan administrators in the third party prepaid prescription program market to determine if there is real competition among these firms or if there has been a de facto division of the market by these competitors. *Problems of Third Party Prepaid Prescription Programs* at 17.

The report voiced a Congressional concern that "programs" such as that of Blue Shield pose a "threat . . . to the continued existence of the independent retail pharmacies." *Problems of Third Party Prepaid Prescription Programs* at 15. Perhaps most significant of all, the report suggests a Congressional belief that Blue Shield's challenged activities

are not a part of the business of insurance. The Department of Justice's inaction in dealing with these activities was rebuked as follows:

> [T]he subcommitte is of the opinion that the Department [of Justice] still fails to recognize the inequities faced by independent retail pharmacists as a result of these programs and has not yet taken a realistic view of the competitive factors which dictate their participation. Until this is done, the competitive position of the independent pharmacist will continue to diminish to the point where the continued existence of this vital sector of the economy is threatened. *Problems of Third Party Prepaid Prescription Programs* at 15.

By no stretch of the imagination can it be said that Congress considers Blue Shield's "cost containment" activities to be part of the business of insurance or that Congress urges such activities.

In their efforts to create the illusion of governmental support for their activities, Petitioners attribute to the Attorney General of Texas the assertion that " 'group health or group medical plans' with provider agreements of the type offered by Blue Shield 'came into vogue during the depression.' " (Brief for Petitioners at 21). Once again, Respondents caution the Court to review carefully the Attorney General's opinion to which Petitioners are referring. As was discussed at pages 29-32, *supra*, the provider agreement utilized by the corporation being studied by the Attorney General differs vastly from The Pharmacy Agreement being utilized by Blue Shield in conjunction with its other coercive activities. Additionally, Petitioners have perverted the Attorney General's statement, which was as follows:

> We can find no cases in this or other jurisdictions passing upon arrangements exactly the same as that herein involved. It resembles in some respects and is presumably based upon medical plans previously passed upon by the courts of certain other jurisdictions, primarily the group health or group medical plans which came into vogue during the depression. (App. 478a).

That Petitioners can derive their assertion from that statement actually made by the Attorney General is highly curious.

Even more incredible is Petitioners' assertion that at the time the McCarran Act was passed, "Congress was aware of the use in the Health insurance business of third-party provider agreements *similar to those in issue here*." Brief for Petitioners at 22. To support this proposition, Petitioners note that Attorney General Biddle testified during joint Congressional committee hearings that he interpreted the Court's opinion in *American Medical Association v. United States*, 317 U. S. 519 (1943), to hold that prepaid health care plans were the business of insurance. *Id.* Petitioners then claim that the *AMA* case "bears strong similarities to the instant case" and that in the *AMA* case, Group Health Association, Inc. "had entered into agreements with 'participating providers.' " *Id.* Evidently, this Court is supposed to conclude that the activities challenged herein parallel the agreements between Group Health Association, Inc. and its *employee* physicians in the *AMA* case, and that Congress considered the employment contracts in the *AMA* case to be a part of the "business of insurance." Neither of these concepts has any validity.

As the Court clearly stated in the *AMA* case, "Group Health *employed* physicians on *a full time salary basis* . . . ." 317 U. S. at 526 (emphasis added). Further, it noted that "the doctors having contracts with Group Health *were em-*

ployees of that corporation." 317 U. S. at 535-36 (emphasis added). The activities being challenged were the defendants' efforts "to prevent anyone from taking employment under Group Health." 317 U. S. at 536. There is absolutely no correlation between the challenged activities herein and the *AMA case*, the employment contracts in the *AMA* case, or the challenged activities in the *AMA* case. Nor there any indication that Congress considered the employment contracts in the *AMA* case to be a part of the business of insurance. Indeed, the Texas Attorney General's opinion cited in several instances by Petitioners states that when a corporation pays doctors "a fixed annual compensation" to render medical services to the corporation's subscribers, "the business [is] . . . not . . . insurance in nature." App. 478a-479a. Texas would not consider the arrangement before the Court in the *AMA* case to be "the business of insurance."

The protestations by Petitioners and their amici that Petitioners' anticompetitive activities are being conducted with the knowledge, acquiescence, and urging of government officials and agencies should be familiar to the Court. Similar arguments have often been made by entities that have desired a license by the Court to violate the federal antitrust laws. Similar arguments were made by the defendants in *United States v. Socony-Vacuum Oil Co.*, 310 U. S. 150 (1940), who sought "to establish that the Petroleum Administration Board knew . . . [of their price fixing activities] and acquiesced in them." 310 U. S. at 207. The Court rejected such knowledge and acquiescence as a viable consideration.

> As to knowledge or acquiescence of officers of the Federal Government little need be said. The fact that Congress through utilization of the precise methods here employed could seek to reach these same objectives sough by respondents does not mean that respon-

> dents or any other group may do so without specific Congressional authority. Though employees of the government may have known of those programs and winked at them or tacitly approved them, no immunity would have thereby been obtained. Otherwise national policy on such grave and important issues as this would be determined not by Congress nor by those to whom Congress had delegated authority but by virtual volunteers. . . . . The fact that the buying program may have been consistent with the general objectives and ends sought to be obtained under the National Industrial Recovery Act is likewise irrelevant to the legality under the Sherman Act of respondents' activities . . . For as we have seen price-fixing combinations which lack Congressional sanction are illegal per se; they are not evaluated in terms of their purpose, aim or effect in the elimination of so-called competitive evils. 310 U. S. at 225-28.

In their program of "cost containment" for the retail pharmaceutical industry, Petitioners likewise seek to usurp the role of Congress and are acting as volunteers to determine a matter of national policy. They cannot be allowed to do so under the fiction that they merely are engaging in the business of insurance.

E. Congress Did Not Intend To Sacrifice Price And Other Forms of Competition In Provider Industries To The Whims of Insurers And State Insurance Commissioners In Their Professed Search For Ways To Lower Insurance Rates

1. The McCarran Act Does Not Vest Insurance Companies With A License To Impose Their Own Private System of Wage-Price Controls on Provider Industries

Petitioners and their amici contend "cost containment" is a primary responsibility of the "business of insurance."

See, e.g., Amicus Curiae Brief of the Blue Shield Association (Brief of Blue Shield Association) at 10-11. They argue that insurance companies have a "responsibility" to "contain" the costs of "provider" industries. Although Petitioners and their amici speak mainly of containing health care costs, the National Association of Insurance Commissioners intimate that the "cost containment initiatives" or "experiments" should be expanded to other areas such as automobile repair. *See* NAIC Brief at 41-43. Among the insurance benefits currently in vogue are medical benefits, dental benefits, optional benefits, accident and sickness disability benefits, death benefits, and prescription drug benefits. Presumably these are all ripe areas for "cost containment experiments". Indeed, the number of industries that would be affected by this Court's holding Petitioners' challenged activities to be the business of insurance is staggering. Any industry selling goods or services that are purchased in whole or in part by the proceeds of insurance is a potential target for insurers' prices fixing activities — or "cost containment experiments."

Congress never intended that the McCarran Act or any other act serve as a vehicle whereby insurance companies, large labor unions, and large employers could combine with the larger members of a provider industry to determine what prices should be charged by that industry. Congress never intended that the McCarran Act oust the protections of the federal antiturst laws from every industry selling goods or services that are purchased with the proceeds of insurance. The legislative history of the McCarran Act shows no feeling in Congress that insurers or state insurance regulators are somehow magically endowed with the resources and broad expertise necessary to determine what constitutes a fair market price in the various non-insurance sectors of our economy.

Petitioners' "cost containment" activities fly in the face of the basic philosophy underlying the antitrust laws — that unrestricted competition will yield the most efficient allocation of eonomic and other resources, the highest quality of goods produced, and the *lowest prices*. Repeatedly, the Court has recognized this philosophy of the antitrust laws.

> The Sherman Act reflects a legislative judgment that ultimately competition will not only produce lower prices, but also better goods and services. . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain — quality, services, safety, and durability — and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers. Even assuming occasional exception to the presumed consequences of competition, the statutory policy precludes inquiry into the question whether competition is good or bad. *National Society of Professional Engineers V. United States*, ... U.S. ....., 98 S. Ct. 1355, 1376 (1978)

Petitioners would have the Court believe that Congress, in enacting the McCarran Act, intended to displace this philosophy and to replace it with a system whereby insurance companies would be allowed to determine what forms of competition are to be allowed, what prices are to prevail and even what businesses would be allowed to exist. It is incredible to argue that Congress intended to establish a system of private economic regulation for all "provider industries," subject only to the State insurance commissioners' oversight.

The threat to our free economy that would be imposed by the Court's sanctioning Petitioners' private system of economic regulation is enormous.

> If a decision is to be made to sacrifice competition in one portion of the economy for greater competition in

> another portion this is a decision that must be made by Congress and not by private forces or by the courts. *United States v. Topco Associates, Inc.*, 405 U. S. 596, 611 (1972).

Respondents respectfully submit that Congress has not demonstrated a desire to sacrifice competition in provider industries for the benefit of insurance companies or for the benefit of large labor unions and large employers. Such an intention by Congress is not to be lightly implied. More is at stake here than abstract innocuous principles.

> Antitrust laws in general, and the Sherman Act in particular, are the Magna Carta of free enterprise. They are as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms. And the freedom guaranteed each and every business, no matter how small, is the freedom to compete — to assert with vigor, imagination, devotion, and ingenuity whatever economic muscle it can muster. Implicit in such freedom is the notion that it cannot be foreclosed with respect to one sector of the economy because certain private citizens or groups believe that such foreclosure might promote greater competition in a more important section of the economy. *United States v. Topco Associates, Inc.*, 405 U. S. 596, 610 (1972).

Petitioners desire to do away with the concept that the essence of the business of insurance is the underwriting of risks in return for a premium. They want to convert insurance companies into massive cooperative buying units or purchasing agents, with McCarran Act licenses to utilize the threat of boycotts by their many insureds to coerce entities in provider industries to set their prices at levels determined by insurers, large labor unions, large employers, and the

larger members of the provider industries. The McCarran Act cannot serve as a license for such tampering with free market forces.

In August, 1971, wage-price controls were imposed on most sectors of the economy. In April, 1974, price controls were lifted from the health indusrty. They were not lifted with a mandate to Blue Shield, the UAW, the Motor Vehicle Manufacturers, and the large pharmacy chains to impose their own private price controls and market allocation schemes on the retail pharmaceutical industry.

2. State Insurance Commissioners Do Not Have A Congressional Mandate To Determine What Prices And What Forms of Competition Are To Prevail In The Various Industries Selling Goods That Are Purchased With The Proceeds of Insurance

Petitioners and their amici intimate that any abuses arising from Petitioners' challenged activities will be held in check by the State Insurance Commissioners. They argue that their challenged activities must be immunized from antitrust scrutiny as the "business of insurance" or State Insurance Commissioners will be hindered in their efforts to regulate insurance rates, and state regulation of the insurance will be disrupted.

These arguments are fallacious. Petitioners' challenged activities have nothing to do with an insurance commissioner's regulating the rates of insurancee. The speciousness of the arguments is underscored in the context of this case by the fact that the Texas State Board of Insurance *does not* regulate rates for accident and health insurance nor for prepaid presoription drug insurance (Pogue Depo. at 64), and it does not regulate the amounts to be paid to providers of benefits under health and accident insurance policies

(Pogue Depo. at 59-60). By no stretch of the imagination can Petitioners argue that their challenged activities are being undertaken in response to duress, request, or even simple urging by the Texas Commissioner of Insurance. The Commissioner does not even have authority to regulate Blue Shield's rates in Texas, much less urge or tacitly approve the activities challenged herein.

The Blue Shield Association's argument that the Court's subjecting Petitioner's challenged activities to scrutiny under the federal antitrust laws will interfere with State Insurance Commissioners' regulation of insurers' raes is ludicrous in light of responses by the Association's members to rate regulation. When the Commissioner of Insurance in Michigan recently tried to regulate the premium rates of Blue Cross and Blue Shield of Michigan, he was met with the following argument by that company:

> [T]he Commissioner's rate approval powers are limited to investigating whether the rates proposed will provide sufficient revenues to administer and fund benefits which BCBSM has determined and contracted to provide and to maintain the reserve levels approved by the Commissioner. Brief on Appeal — Appellant at 6, *Blue Cross and Blue Shield of Michigan v. Demlow*, Cause No. 59320 (Mich. Sup. Ct., filed 1977).

He was met with the additional argument by Blue Cross and Blue Shield that *it is not an insurance company* and is not subject to broad regulation by the Commissioner of Insurance! *Id.* 12. One can only conclude that Petitioners want as little regulation of their activities as possible. When faced with a choice between scrutiny under the federal antitrust laws and the minor inconveniences posed by State Insurance Commissioners ,they strenuously clamor for the latter.

The State Insurance Commissioners are receptive to this clamor because they are interested in expanding their authority at the expense of the federal antitrust laws. The NAIC argues that it and not the federal courts should determine what constitutes the "business of insurance" in the arena of insurer's activities ostensibly aimed at "cost containment." NAIC Brief at 45-47. Under the NAIC standard, *any* activities undertaken by insurers with the motive of reducing the cost of insurance is the "business of insurance" regardless whether the activity's focus is on another industry.

Although Congress clearly intended to give the States power to regulate insurance rates free from federal interference, it never intended to vest States or their Insurance Commissioners with preeminent exclusive regulatory authority over the prices, wages, and competitive activities in all private, non-insurance industries selling goods or services that might be purchased with the proceeds of insurance policies. Congress did not intend to remove the protections of the federal antitrust laws from these private non-insurance industries. To hold otherwise would allow the McCarran Act exception to swallow a huge portion of our free market economy.

Virtually any interaction between insurers and private, non-insurance industries will have some effect on an insurer's costs of doing business and hence its rates. That fact, however, is insufficient to substitute state regulation of private, non-insurance industries for that of the federal antitrust laws.

The McCarran Act's legislative history demonstrates that Congress never intended to install State Insurance Commissioners as the ultimate arbiters of insurance companies'

efforts to fix prices and eliminate competition in private, non-insurance industries. There was no expression of confidence in the efficacy of such regulation as a substitute for free market forces. The Act's history demonstrates a desire to circumscribe the State's regulatory authority within narrow, traditional parameters.

> It is not the intention of Congress in the enactment of this legislation to clothe the States with any power to regulate or tax the business of insurance beyond that which they had been held to possess prior to the decision of the United States Supreme Court in the Southeastern Underwriters Association case . . . In other word, we give to the States no more powers than those they previously had, and we take none from them. 91 CONG. REC. 1442 (1945) (remarks of Senator McCarran).

The desire obviously arose from a distrust of the competitive evils that would be wrought by a broad exemption.

> Mr. Speaker, this bill is a compromise, but it is well to keep in the background the tremendous power and potency of the various large insurance companies. We have to make a decision sooner or later as to whether or not we are going to be ruled by a cabal or a combination of these powerful companies or whether we are going to allow the small independent companies to function under competitive conditions in the various States. 91 CONG. REC. 1087 (1945) (remarks of Congressman Celler).

> The proponents of this legislation take too much for granted. Because the insurance officials of a few States, whose political policy is controlled and directed by the ramifications of these huge insurance combines, approve the McCarran bill, they would have the Members of Congress believe that a satisfactory agreement has been

> reached and that this bill has been sugar-coated so it pleases everybody. I doubt seriously if any of the "sugar" got into the bill. I shall later show how and why it will be "sour grapes" to the little businessman in the cities, villages, and at the crossroads who cannot pay his Federal, State, and local taxes, and at the same time pay tribute to these insurance barons. 91 CONG. REC. 1091 (1945) (remarks of Congressman Bailey).

Against such background, Petitioners and their amici would have the Court believe that Congress intended to sacrifice price and other forms of competition in provider industries to the whims of insurers and State insurance commissioners in their professed search for ways to lower insurance rates. The proposition is repugnant to reason and reality.

These same insurance commissioners who desire to control prices and competition in provider industries have been less than fervent in their efforts to control the rates of Blue Cross and Blue Shield — an activity clearly within the business of insurance. In 1971, the net income of Blue Cross plans was $85 million. In just the one year 1971 to 1972 alone this income rose by more than 276% to $230 million. In the two years from 1971 to 1973, the net income of Blue Cross plans increased by over 415% to $438 million! Mueller, *Private Health Insurance in 1973: A Review of Coverage Enrollment and Experience*, 38 SOC. SEC. BULL. 21, 34 (Feb. 1975). It must be noted that these figures for net income are very conservative since they do not include the amounts placed in reserves, which have likewise dramatically increased. The Blue Cross plans' reserves increased by 41% in the one year from 1971 to 1972, from $747 million to $1.05 billion. Mueller, *Private Health Insurance in 1972: Health Care Services, Enrollment and Finances*, 37 SOC. SEC. BULL. 20, 36 (March 1973). In

1973, the reserves rose an additional 40% to $1.46 billion. Mueller, *Private Health Insurance in 1973: A Review of Coverage Enrollment and Experience*, 38 SOC. SEC. BULL. 21, 34 (Feb. 1975).

These figures are not at all surprising when one analyzes the relationship between the NAIC and the Blue Cross-

Blue Shield organizations in whose behalf it has filed an amicus brief herein. During the 1974 NAIC convention, several newly appointed insurance commissioners questioned the standard practice of having more insurance company representatives at NAIC meetings than State regulators. Their suggestion that the regulators meet separately from the representatives of the industry they were purportedly regulating was rebuffed since the insurance industry is the major source of the information on which the NAAIC depends and provides money for the conventions and other NAIC activities. S. LAW, BLUE CROSS *WHAT WENT WRONG?* 164 (2d ed. 1976).

State insurance commissioners do not have the resources or the expertise to regulate prices and competition in the multitude of provider industries. State insurance commissioners do not have the resources to analyze each of these industries in the detail necessary to determine what is a "fair" market price. They do not have the expertise to determine what prices will give a "fair" return on capital in each of these industries. The underlying costs, which an industry's prices must reflect, change from day to day as well as from hour to hour. How could state insurance commissioners continually monitor the multitude of provider industries to determine when each one's expenses had risen sufficiently that a price increase would be allowed?

On page 48 of its amicus brief, the NAIC expresses it view that the $2.00 professional dispensing fee agreed upon by Petitioners is bound to be "an adequate level of reimbursement" because such figure was agreed upon "by several pharmacies including certain individual Respondents." This statement concerning adequacy of the $2.00 dispensing fee shows a fatal lack of understanding concerning the retail pharmacy industry and flies in the face of Congressional studies. In answering a similar expression of opinion, one Congressional report noted the following:

> Likewise overlooked in the Department of Justice's economic analysis is the different emphasis competing providers of pharmacy services place on the importance of their prescription counter's profits. To the small, independent retail pharmacist, dispensing medicine is the essence of his business. The profits derived from this service are the basis of his income and enable him to continue operating as a small businessman. Whatever else is sold in his store is primarily done so because the pharmacist wishes to offer his customers the convenience of purchasing some essential items in the same place that they have their prescriptions filled . . . But in some cases, the existence of a prescription counter is a peripheral item; there as a service to customers who have come into the store to buy other items. Indeed, its existence may really only be means of attracting customers into the store knowing that they will purchase other items while waiting for their prescriptions to be filled. Under such circumstances, the profits directly derived from dispensing drugs may not be as important as the indirect profits which result from purchasing of other items. As the prescription counter may only be a come-on, this type of store would be willing to sustain only marginal profits from the operation of this department, knowing that the volume of business generated by its presence will produce

profits in other departments which will justify the cost of installing a prescription counter. As profits are not the primary consideration for the existence of a prescription counter in this type of store, they can hardly be considered a significant factor in inducing this store to partcipate in a third-party program. Indeed, these programs may be a financial boom to such stores, in that they assure some profits for dispensing drugs. The Department of Justice has yet to acknowledge that profits are not always the major motivation for the existence of prescription counters in some stores and the fact that such situations exist places the independent retail pharmacist in a seriously disadvantageous competitive position to the extent that they jeopardize his continued existence as a small businessman.

> The independent retail pharmacist's problems become more acute when a store which establishes a prescription counter as a come-on to attract customers agrees to participate in a third party prepaid prescription program, for once this happens, the small independent pharmacist has, in effect, lost his freedom of choice and is now compelled by the economic realities of an unbalanced competitive market to participate. Since the prescription counter is the basis of his business, the loss of existing clientele would mean financial ruin, while to the large competitor, participation only offers an opportunity to increase the volume of a marginally profitable department. Thus, to the independent, participation may offer the only mechanism for economic survival and may necessitate the incursion of diminished profits as the only means of staying in business. *Problems of Third Party Prepaid Prescription Programs* at 13-14.

Elsewhere, the report noted that "because of the inflexibility in the method of determining his fee, participation in third

party programs may also result in financial failure. Herein lies the essence of the pharmacist's dilemma." *Id.* 6.

The NAIC's lack of understanding of the retail pharmacy industry is not surprising. After all, in pushing for "cost containment experiments" in provider industries, the NAIC is not seeking to further the competitive health of the provider industries. The NAIC has but one interest—each insurance commissioner is on the "public 'firing line' " to make reliable insurance available at low rates. *See* NAIC brief at 46. The fact that lower insurance rates might be achieved at the expense of competition in prices and customer services in provider industries and at the expense of society's losing small, independent businessmen is of no concern to the insurance commissioner. His performance is not measured in terms of these parameters. He is not accountable to the provider industries nor to the public for performance of these industries. To hold that Congress intended these individuals to sit as final arbiters over conspiracies between insurers and large providers to fix prices and eliminate competition in customer services in provider industries is repugnant to all reason. Congress could not have intended that the McCarran Act effect so broad a retreat from the Sherman Act, for, as this Court has articulated,

> In enacting the Sherman Act, . . . Congress mandated competition as the polestar by which all must be guided in ordering their business affairs. It did not leave this fundamental national policy to the vagaries of the political process, but established a broad policy, to be administered by neutral courts, which would guarantee every enterprise the right to exercise 'whatever economic muscle it can muster,' . . . without regard to the amount of influence it might have with local or state legislatures. *City of Lafayette v. Louisiana Power &*

Light Co., U. S. , 98. S. Ct. 1123, 1133-34 (1978), *quoting in part United States v. Topco Associates, Inc.*, 405 U. S. 596, 610 (1972).

F. The McCarran Act Does Not Automatically Immunize Every Aspect of Contractual Relationships Between Insurers and Providers Of Benefits From Scrutiny Under The Federal Antitrust Laws.

Petitioners argue that the Fifth Circuit's Decision "stands alone in its unrealistic attempt to separate the health care provider agreement from the underlying contract of insurance." Brief for Petitioners at 25-26. They further argue that "all other courts have uniformly held that participating agreements" between insurers and providers "are an integral part of the 'business of insurance.'" Brief for Petitioners at 26-27. Petitioners' arguments misconstrue the Fifth Circuit's decision, overlook other relevant judicial decisions and attribute a breadth to cited decisions that just is not present.

There is no body of precedent holding that all contracts between insurance companies and providers of benefits, which in some manner concern the provision of benefits, are automatically immune from antitrust scrutiny with respect to *all activities and conspiracies* embraced or contemplated by the contracts. Petitioners desire that this Court grant such blanket McCarran Act immunity. The Fifth Circuit refused to cripple the economic freedoms guaranteed by the federal antitrust laws in the manner urged by Petitioners. It recognized that federal courts cannot allow insurer's ingenious exercises in packaging or camouflaging to remove from federal antitrust scrutiny that which is not the business of insurance. There is nothing sacred about "provider agreements" that precludes a federal court's looking beyond their

surface to see if they embrace or contemplate activities that are not a part of the business of insurance and thus not entitled to McCarran Act immunity. The Fifth Circuit did not hold that all "provider agreements" and all aspects of such agreements are outside the business of insurance. Rather, it held that federal courts must scrutinize challenged activities to see if they, regardless of the window dressing, are a part of the business of insurance. "[S]uch practices do not become clothed with McCarran Act protection *simply because* an insurance company has contracted to pay the provider for products or services." 556 F. 2d 1386, App. 137a, (emphasis added).

Petitioners want the Court to expand the McCarran Act's immunizing effects by granting blanket antitrust exemptions for any and all activities embraced or contemplated by contracts between a health insurer and providers of benefits. Petitioners' "provider agreement" argument is contrary to the McCarran Act. It would make antitrust immunity dependent solely on the existence of contractual arrangements between an insurer and non-insurance parties, not on satisfaction of the McCarran Act's requirements. It would mean that any direct contract between an insurer and providers of benefits automatically would exempt the contracting parties from the federal antitrust laws, irrespective whether the various activities contemplated by the parties actually are a part of the "business of insurance" as the McCarran Act requires. It thus creates an antitrust exemption not conferred by Congress. While Petitioners' argument has the virtue of simplicity, it is patently invalid and finds no support in the McCarran Act. Activities do not become a part of the "business of insurance" merely because they are contemplated or embraced by a contract to which an insurer is a party.

A second fallacy of Petitioners' argument is its premise that the activities challenged by Respondents are "an inseparable feature of prepaid health policies which are regulated by the states." The Fifth Circuit correctly found that the price fixing and coercion practiced by Petitioners are *not* an inseparable feature of Blue Shield's health insurance policies, are not peculiar to the "business of insurance and are not regulated by Texas as a part of the "business of insurance."

The setting of retail prices in the various private sectors of our economy certainly is not encompassed by the business of insurance. As the Fifth Circuit correctly recognized, an insurer "is not required to guarantee the provision of services on a 'cost-plus' basis or any other basis which might be more economical than the retail purchase of such products." (556 F. 2d at 1382, App. 129).

Contrary to Petitioners' assertions, there is no great body of precedent holding that "provider agreements" are inseparable from the underlying contract of insurance and, *together with all their attendant activities*, are automatically a part of the business of insurance. Each of the cases cited by Petitioners involved its own unique set of facts and of state law. To the extent any of the cases recognized activities such as those challenged herein to be the business of insurance, Respondents respectfully submit that the cases were wrongly decided.

One case, more than any other, is cited as authority justifying McCarran Act immunization of insurers' perversions, permutations, and abuses of "provider agreements." That case is *Travelers Ins. Co. v. Blue Cross*, 481 F. 2d 80 (3d Cir.), *cert. denied*, 414 U. S. 1093 (1973). Petitioners heavily relied on *Travelers* in the Fifth Circuit and again cite the

case in their brief before this Court. *Travelers* is an unfortunate case because it is all too easily misconstrued and stretched beyond its limited holding. *Travelers* involved a very special fact situation wholly unlike that before this Court. It cannot be cited for the proposition that contractual relationships between insurers and the providers of benefits, which relate in some manner to the provision of benefits, necessarily constitute the business of insurance. To cite it for this proposition is to ignore the case's specialized factual setting and the fact that the Third Circuit's holding is in reality a very narrow one based on unique features of Pennsylvania Law.

It is true that *Travelers* involved a direct contractual relationship between an insurer and the providers of benefits. However, the similarity between that case and the present controversy ends with this single characteristic. The fact that there was a *direct contractual relationship* between Blue Cross and the providers of benefits, some non-profit hospitals, did not in itself serve on the basis for the Third Circuit's opinion. Only after one reads the District Court's opinion in *Travelers*, and thereby gains an understanding of the highly specialized facts in that case, can the true basis of the Third Circuit's opinion be understood. *See Travelers Ins. Co. v. Blue Cross*, 361 F. Supp. 774 (W.D. Pa. 1972), *aff'd*, 481 F. 2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973).

In a case decided by the United States District Court for the Eastern District of Pennsylvania, the Court correctly observed that the decision in *Travelers* was based on the specialized provisions of Pennsylvania law — provisions having no counterpart in Texas and that are totally alien to the facts of the present controversy. *See Doctors, Inc. v. Blue Cross*, 431 F. Supp. 5 (E. D. Pa. 1975), *aff'd per curiam*,

557 F. 2d 1001 (3d Cir. 1976). The Court in *Doctors, Inc.* correctly construed the narrowness of the Third Circuit's holding in *Travelers*, with the following observation:

> It is therefore readily apparent from the reading of the *Travelers* case that *the Third Circuit is approving the actions of the Insurance Commissioner of Pennsylvania* when he exerts pressure on the large insurance companies to get them to exercise their power over hospitals to cut costs wherever possible.

431 F. Supp. at 10 [emphasis added]. The fact that there was a direct contractual relationship between Blue Cross and the non-profit hospitals was not in itself important.

Of crucial importance to the *Travelers* opinion was the fact that *Pennsylvania's legislature had chosen to control the rates charged by non-profit hospitals* through a statutorily created interrelationship between the rates charged by non-profit health insurers and non-profit hospitals, which interrelationship was to be regulated by the Pennsylvania Insurance Department. As the District Counrt observed in *Travelers*,

> "the activities of Blue Cross in all respects material to this case, *including the terms of the contract under attack*, are regulated and *directed* by the Insurance Department of the Commonwealth of Pennsylvania in strict conformity with the provisions of the Nonprofit Hospital Plan Act of 1973 . . ."

Travelers Ins. Co. v. Blue Cross, 361 F. Supp. 774, 776 (W. D. Pa. 1972) [emphasis added]. Additionally, it observed the following with respect to Pennsylvania's Nonprofit Hospital Plan Act:

> Under the terms of said Act, Blue Cross having been previously organized under the Pennsylvania Nonprofit Corpoartion Law . . . for the purpose of establishing, maintaining and operating such a *non-profit hospital plan* became subject to regulation by the Pennsylvania Insurance Department in the following respects:
>
> 'the rates charged to subscribers . . ., *all rates of payments to hospitals . . ., and any and all con-contracts entered into . . . with any hospital.' . . . The Blue Cross Hospital contract is, therefore, an integral part of Pennsylvania's regulated hospital plan.*"

361 F. Supp. at 777. [emphasis added]. It can be seen, then, that the Pennsylvania legislature had chosen to directly control the rates charged by non-profit hospitals by charging the Insurance Department with the task of directing and controlling the terms of contracts between *non-profit* health insurers and non-profit hospitals and with controlling the rates of payments by insurers to non-profit hospitals.

The role of the Pennsylvania Insurance Department in determining the terms of Blue Cross' contracts with non-profit hospitals is very extensive as is shown in *Frankford Hospital v. Blue Cross*, 1976-2 Trade Cases ¶ 61,030 at 69,547 (E.D. Pa. June 8, 1976), *aff'd*, 554 F. 2d 1253 (3rd Cir.), *cert. denied*, ... U.S. ....., 98 S. Ct. 186 (1977). *Frankford* involved a challenge by a non-profit hospital to Blue Cross' contract with hospitals. The District Court relied on the *Travelers* opinion and stressed as follows:

> "Both the rates Blue Cross charges to subscribers and its rate of payments to hospitals must be approved in advance by the Insurance Department before they can go into effect. 40 Pa. C.S.A. ¶6124. . . . The Department instructed Blue Cross to develop a uniform contract [with non-profit hospitals]. It particularly

> stressed that this contract should include the cost accounting principles upon which reimbursement under the federal Medicare Program was based."

5 Trade Reg. Rep. at 69,548. The Court noted that when Blue Cross first submitted its proposed uniform cost contract between itself and Philadelphia area hospitals, the contract was rejected by the Insurance Commissioner, who instructed Blue Cross that it was not to pay for any portion of the hospitals' unreimbursed outpatient cost or for costs of depreciation. The Commissioner viewed these costs as a "community responsibility, including federal, state and local governments as well as eleemosynary institutions . . ." 5 Trade Reg. Rep. at 69,549.

Finally, the Hospital Agreement of 1971 was approved, "the terms of which reflected Commissioner Denenberg's negotiating guidelines.. *Id.* When the 1971 Agreement expired in 1974, a number of hospitals refused to sign a new hospital agreement with Blue Cross, in response to which "the Commonwealth of Pennsylvania enacted Act. No. 94 of 1975, (40 P.S. ¶ 6124c). It reinstated, retroactively, the 1971 Hospital Agreement between Blue Cross and the non-member DVHC hospitals." 5 Trade Reg. Rep. at 69,550.

It was against this factual background, then, absent the 1975 statute, that the Third Circuit in *Travelers* held the contract between a non-profit health insurer and non-profit hospitals to be shielded by the McCarran Act from attack. Considering this factual background, it is evident that the *Travelers* opinion is of no precedential value in the present controversy and certainly cannot be cited for the broad proposition that contractual relationships between an insurer and a provider of benefits are *ipso facto* shielded by the McCarran Act from antitrust challenge. The mere fact

that a conspiracy to fix prices is embodied in an agreement between an insured and a provider does not invoke McCarran Act immunity. The Third Circuit in *Travelers* was not confronted with a conspiracy to fix prices; nor was it confronted with a conspiracy to coerce providers of benefits to fix their prices. It was confronted with a *State created* and *State controlled* plan for not only regulating, but mandating, the rates charged by non-profit hospitals. The State legislature had expressly provided that Pennsylvania's Insurance Department would control and *direct* the terms of contracts between non-profit insurers and non-profit hospitals and had expressly created an interrelationship between non-profit health insurers' rates and those of non-profit hospitals, which interrelationship was also to be regulated by the Pennsylvania Insurance Department. Given this background, there can be no doubt that the terms of the contract challenged in *Travelers* were in effect created by the Pennsylvania legislature as a part of the non-profit health insurance and non-profit hospital plans in Pennsylvania. Activities such as those challenged herein were not before the Third Circuit in *Travelers.*

Texas has no plan even remotely analogous to that of Pennsylvania as concerns pharmacies, the rates charged by pharmacies, the rates charged by prescription drug insurers, and the interrelationship of the rates charged by pharmacies and insurers. Unlike the Pennsylvania plan involving *non-profit hospitals* and *non-profit insurers*, there is no statute in Texas by which the legislature seeks to control directly or indirectly the prices charged by retail pharmacies. Retail pharmacies are an entirely private sector of the economy, are not subsidized in whole or in part by the State, and operate for profit. There is no statute in Texas by which the legislature seeks to control the premium rates for Blue

Shield's prescription drug insurance nor the amounts of Blue Shield's reimbursements for prescription drugs. The Texas legislature has not chosen to indirectly or directly control the rates charged by pharmacies by directing and controlling contracts between insurers and pharmacies and by creating an interrelationship between the rates charged by pharmacies and those charged by insurers. As Blue Shield's house counsel admitted in deposition testimony, Texas law does not require that the Pharmacy Agreement be submitted to or approved by the State Board of Insurance (McDonald Depo. at 57, App. 302a). In short, the State of Texas *has not regulated, authorized, directed, sanctioned, nor created* the Pharmacy Agreement that is under scrutiny in this case. The Commissioner of Insurance has not directed Blue Shield to force pharmacies to cut costs wherever possible. The Texas legislature has not attempted to make contracts between insurers and pharmacies part of the business of prescription drug insurance. None of the factors in *Travelers* are present in this case. We are dealing with a wholly private sector of the economy, unlike the situation in *Travelers* involving non-profit hospitals, who are underwritten to a large extent by public and charitable funds. We are dealing entirely with private actions, those of volunteers who seek to set prices and eliminate competition by virtue of their conspiracy and coercion.

It is a gross perversion of the Third Circuit's language to cite *Travelers* for the proposition that a price fixing conspiracy between a profit-making insurance company and profit-making pharmacies is part of the business of insurance as long as it is embodied in a "provider agreement." *Travelers* cannot be cited for the proposition that the McCarran Act immunizes all activities that "provider agreements" embody or contemplate. *Travelers* involved none of the activities challenged herein.

Two of the cases relied on by Petitioners to support their proposition concerning blanket McCarran Act immunity for "provider agreements" merely are progeny of *Travelers*. *See Doctors, Inc. v. Blue Cross*, 557 F.2d 1001 (3d Cir. 1977), *aff'g. per curiam* 431 F. Supp. 5 (E.D. Pa. 1975); *Frankford Hospital v. Blue Cross*, 554 F.2d 1253 (3d Cir.), *cert. denied*, ... U.S. ....., 98 S. Ct. 186 (1977). Both cases involved non-profit hospitals, unique features of Pennsylvania law, and Pennsylvania's Nonprofit Hospital Plan Act. In each case, the Third Circuit succinctly stated it was merely following its *Travelers* holding.

Petitioners' reliance on *Anderson v. Medical Service of the District of Columbia*, 551 F.2d 304 (4th Cir. 1977), *aff'g per curiam*, 1976-1 Trade Cases ¶ 60,884, at 68,855 (E.D. Va. 1976), to create a conflict with the Fifth Circuit's decision is also misplaced. Although *Anderson* did involve direct contractual relationships between an insurer and the providers of benefits, physicians, the opinion was not based on the mere fact that the challenged activity was embodied in a "direct" contract between an insurer and providers of benefits nor on the alleged inseparability of "provider agreements" from the underlying contract of insurance. The district court in *Anderson* stressed the fact that the challenged activity did not operate to fix prices. The court further stressed that the insureds were not coerced to patronize participating physicians *and that policy benefits were the same* whether the subscriber patronized a participating or non-participating physician. 5 Trade Reg. ¶ 60,884, at 68, 857. The fact situation in *Anderson* differs markedly from this case where prices are fixed and Blue Shield's subscribers

must pay a sizeable financial penalty in the form of markedly reduced policy benefits if they patronize non-participating pharamacies.

Another of the "conflicting" decisions cited by Petitioners is *Proctor v. State Farm Mut. Auto Ins. Co.*, 561 F.2d 262 (D.C. Cir. 1977), *petition for cert. pending*, No. 77-580. *Proctor* cannot be cited for the proposition that all *direct* contractual arrangements between insurers and providers of benefits are automatically a part of the "business of insurance" as Petitioners imply. *See* Brief for Petitioners at 26 n. 23. Rather, the D. C. Circuit emphasized that "[t]he question [whether an activity is part of the 'business of insurance'] is ultimately one of line-drawing, based on the facts of the individual case." *Id.* at 268. The D. C. Circuit cited the District Court's opinion in this case with approval, but did so prior to the Fifth Circuit's correcting the erroneous statements of fact on which the District Court's legal conclusions were premised. If it had been given the benefit of the facts as they actually exist, the D.C. Circuit most assuredly would not have cited the District Court's opinion with approval.

Proctor involves a challenge to a "horizontal agreement [among insurers] to pay or reimburse their policyholders according to a common formula." *Id.* at 264 (emphasis added). In essence, the case involves a challenge to insurers' conspiring among themselves concerning the maximum dollar amount of coverage the insurers will provide per claim for their insureds. The present cause, by contrast, involves a challenge to a conspiracy between an insurer and retail pharmacy chains concerning the retail prices to be charged by the retail pharmaceutical industry for its goods and services. There is no indication that the D. C.

Circuit would consider the later activity to constitute the business of insurance. Additionally, *Proctor* lacks the coercive conduct utilized by Petitioners in their effecting a boycott by Blue Shield's subscribers of pharmacies that refuse to agree on price.

The final case relied on by Petitioners as supporting blanket McCarran Act immunity for "provider agreements" and their attendant activities is *Manasen v. California Dental Services*, 424 F. Supp. 657 (N.D. Calif. 1976), *appeal pending*, Nos. 77-1751 and 77-1752 (9th Cir.), which also relied on the District Court's opinion in this case.

Although *Manasen* does indeed appear to support Petitioners arguments, Respondents submit that *Manasen* was incorrectly decided for the reasons so ably articulated by the Fifth Circuit herein. *See* 556 F.2d at 1385-87, App. 136a-138a.

G. Petitioners' Activities As Challenged Herein Are Not Peculiar To The Insurance Industry And Are Not The Business Of Insurance.

Petitioners desire that this Court articulate a rule of blanket McCarran Act immunity for contracts between insurers and providers and for all activities that such contracts might embrace or contemplate because their challenged activities, if subjected to scrutiny, can be no stretch of the imagination be considered the business of insurance. As the Fifth Circuit concluded,

> "[T]here is no indication that the activities complained of are considered the business of insurance . . . by any common sense interpretation of that term." (556 F. 2d at 1385, App. 135a)

By providing markedly decreased benefits to those subscribers who patronize a pharmacy that refuses to sign the price-fixing agreement, Blue Shield intentionally and overtly coerces its subscribers to boycott these pharmacies. This boycott operates to coerce the non-signing pharmacies to participate in the fixing of prices. Blue Shield effectively forecloses non-signing pharmacies from a significant portion of the market and secures for Participating Pharmacies the sales of prescription drugs required by Blue Shield's claimants. This activity is not peculiar to the insurance industry and does not constitute the business of insurance. When faced with very similar activity in *Hill v. Nat'l Auto Glass Co., Inc.*, 293 F. Supp. 295 (N.D. Calif. 1968), the District Court for the Northern District of California observed as follows:

> [I]t does not seem . . . that the alleged activity involved here, namely securing for particular glass dealers the sales and installation jobs required by Allstate claimants, is a part of the "business of insurance" as that term is normally understood." *Id.* at 296.

The conspiracy and agreement to secure for those pharmacies that have signed the price-fixing agreement the sales of prescription drugs to Blue Shield's subscribers is likewise not the business of insurance. The connection of this activity to the insurance company/policyholder relationship is attenuated. The primary relationships affected are those between competing pharmacies and between the pharmacies and their customers — relationships outside the ambit of the McCarran Act.

In *DeVoto v. Pacific Fidelity Life Insurance Co.*, 516 F.2d 1 (9th Cir. 1975), the Ninth Circuit was faced with an antitrust suit by a New York insurance company, which challenged a combination between the defendant insurance

company and the defendant mortgage banker that effectively foreclosed the plaintiff insurance company from a significant segment of the California market for mortgage protection insurance. Despite the fact that the defendant's acts affected the relationship between an insurance company and prospective policyholders, the Ninth Circuit expressly upheld the District Court's finding that the activity was outside the ambit of the McCarran Act. 516 F.2d at 3. The defendants' acts in foreclosing a competitor from a substantial portion of the market were held to be peripheral to the business of insurance and thus without the protective scope of the McCarran Act. The Court's holding in *DeVoto* applies with full force to Petitioners' activities as challenged herein. The price fixing agreement, coupled with the coercion of Blue Shield's policyholders, effectively forecloses pharmacies that refuse to agree on prices from selling prescription pharmaceuticals to Blue Shield's subscribers. These activities are indistinguishable from those before the Ninth Circuit. As was the case in *DeVoto*, the challenged activities are peripheral to the business of insurance and are thus outside the McCarran Act's protective scope.

In *Battle v. Liberty Nat'l Life Ins. Co.*, 493 F.2d 39 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110 (1975), the Fifth Circuit confronted a fact situation markedly similar to that in this case. *Battle* was an action by several funeral homes and directors against an insurer, which issued burial policies, and the insurer's wholly owned subsidiary, which supplied merchandise and services required by the insurer's policies. When the funeral homes signed contracts with the insurer's ssubsidiary to purchase merchandise and services required by the insurer's policies, they became "authorized" funeral homes for purposes of servicing and furnishing merchandise to the insurer's policyholders. If they refused to contract

with the subsidiary, they were considered "unauthorized" homes. Services provided under the policy differed significantly, depending on whether an insured used an "authorized" or "unauthorized" funeral home. Plaintiffs sought relief under the Sherman and Clayton Acts.

The Fifth Circuit's holding with respect to the insurer's discrimination in benefits, which directly applies to the factual setting of this case, is as follows:

> "It appears that, since the insurance contract confers far more benefits upon the policyholder if he uses an authorized funeral home [pharmacy], the policyholder is subtly coerced into dealing only with the authorized home [pharmacy]. The imposition of this restraint would effectively foreclose the unauthorized funeral director's [pharmacies'] access to a substantial portion of the market." 493 F. 2d at 44-45.

These facts, "if established, would tend to support a finding of unreasonable restraint of trade." 493 F.2d at 44. The defendants sought to avoid the dictates of the Sherman and Clayton Acts by claiming that the McCarran Act exempted their activities from the federal antitrust laws.

Although the Fifth Circuit felt that the facts were inadequately developed to make a conclusive determination on the McCarran Act issue, it gave the following advice for the District Court's benefit on remand:

> "[I]t might be plausibly argued that these facts do not constitute the business of insurance as contemplated by the McCarran Act and thus do not fall within its exemption." 493 F. 2d at 50.

The Fifth Circuit served notice that the insurer "may have exceeded the business of providing burial insurance and encroached upon the business of providing funeral services."

493 F.2d at 50. Its feeling in this regard was prompted by the following observation concerning the insurer's arrangement.

> "[I]t requires the performance of duties beyond those encompassed by the business of insurance, duties that relate solely to the plaintiffs' businesses in the operation of their funeral homes, and thus the defendants' activities fall outside the McCarran Act exemption. While all these obligations are related to the business of insurance, we believe that they are so remotely related as to be subject to the antitrust laws." 493 F.2d at 50.

The Fifth Circuit's observation applies with particular force to the activities challenged herein.

It is curious that in their efforts to distinguish *Battle*, Petitioners presume to know more about the case than does the Fifth Circuit, from whence it came. Petitioners argue that the reasoning of *Battle* is limited to situations where there is no *direct* contract between the insurer and provider of services. Brief for Petitioners at 26 n. 23. This argument was made by Petitioners to the Fifth Circuit, and was rejected by that court. There is nothing unique about a *direct* as opposed to an indirect contract that would suddenly make activities or businesses not otherwise a part of the business of insurance eligible for McCarran Act immunity. The focus must be on the activities themselves. Such focus led the Fifth Circuit to correctly conclude as follows:

> [T]he activity complained of by plaintiffs is not peculiar to the insurance industry. To be sure, price fixing and coercion induced by firms with superior bargaining power are often found in all industries. Thus, Blue Shield's attempts to control costs in the pharmaceutical industry might just as easily be undertaken by a non-

insurance firm attempting to meet a contractual obligation to deliver drugs to a wholesale or retail purchaser. 556 F. 2d 1386, App. 138a.

H. The Texas State Department of Insurance Does Not Consider The Pharmacy Agreement To Encompass Or Constitute The Business Of Insurance And Has Not Undertaken To Regulate It As A Part of Such Business.

Although the determination concerning what constitutes the "business of insurance", as that term is used in the McCarran Act, is a federal question,* and federal interpretations supersede those of the states, *see S.E.C. v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 69 (1959), it would be highly anomalous for a federal court to declare that an activity constitutes the business of insurance when a State's Department of Insurance has made the contrary determination. After all, the McCarran Act is merely intended to prevent federal interference with State regulation of the business of insurance. Congress wanted to assure that the activities of insurance companies in dealing *with their policyholders* would remain subject to state regulation." *S.E.C. National Securities, Inc.*, 393 U.S. 453, 459 (1969). If a State considers an activity not to constitute the business of insurance, federal regulation of that activity could not be construed as interference with with State regulation of the business of insurance. When a State makes the determination that an activity does not constitute the business of insurance, and thereby serves notice that the activity will not be regulated as a part of the business of insurance, the determination should be controlling with the federal courts. A contrary holding by the federal court would in no way further the purposes behind the McCarran Act. Application of the federal antitrust laws in this situation could in no

way be construed as invalidating, impairing, or superseding "any law enacted by any State for the purpose of regulating the business of insurance." *See* 15 U.S.C. § 1012(b) (1970). Additionally, it would violate the Supreme Court's mandate that the antitrust laws are to be liberally applied. *See Abbott Labs. v. Portland Retail Druggists Ass'n.*, 425 U.S. 1 (1976). The McCarran Act like other exceptions to the antitrust laws, is to be construed strictly and has no intendments in its favor.

That Texas does not consider the activities challenged herein to be the "business of insurance" cannot be doubted. The testimony of Mr. Pogue, Director of the Policy Approval Division of the State Board of Insurance, is unambiguous in this regard as is dicussed extensively elsewhere in this brief. Petitioners endeavor to create a contrary impression by citing various Texas statutes that are inapplicable to their challenged activities. With respect to TEX. INS. CODE ANN. art. 21.21 (1963), they argue as follows:

> [I]t was specifically intended by its draftsmen to respond to the invitation of the McCarran Act to withdraw from federal control *the very conduct attacked by respondents in this action* and to place such conduct under state control. Brief for Petitioners at 32-33 (emphasis added).

Petitioners overlook a crucial fact in this argument—article 21.21 only applies to activities that are a part of the business of insurance, which the activities challenged herein are not. The article provides as follows:

> Sec. 4. Unfair Methods of Competition or Unfair and Deceptive Acts or Practices Prohibited. — No *person* shall engage in this state in any trade practice which is defined in this Act as, or determined pursuant to this

> Act to be, an unfair method of competition or an unfair or deceptive act or practice *in the business of insurance.* TEX. INS. CODE ANN. art. 21.21 Sec. 3 (1963) (emphasis added).

"Person" is defined as follows:

> Any individual, corporation, association, partnership, reciprocal exchange, inter insurer, Lloyds insurer, fraternal benefit society, and any other legal entity *engaged in the business of insurance*, including agents, brokers, adjusters and life insurance counselors. TEX. INS. CODE ANN. art. 21.21 Sec. 2 (1963) (emphasis added).

There is absolutely no indication that Texas or its Department of Insurance considers Petitioners' challenged activities to be the business of insurance in order to invoke article 21.21.

Petitioners' conclusion that article 21.21 applies to the challenged combination and conspiracy to fix the prices of pharmaceuticals directly conflicts with the testimony of Mr. A. W. Pogue, who is the official charged with reviewing the documents within the jurisdiction of the State Board of Insurance "to make sure that they comply with the statutory requirements as set forth in the Insurance Code [including those of article 21.21]" (Pogue Depo. at 13, 33-34, App. 324a-325a, 335a-336a). Since Mr. Pogue is charged with screening documents within the jurisdiction of the Board of Insurance for compliance with article 21.21, and since, as is discussed extensively above, he takes the position that The Pharmacy Agreement is not a part of the business of insurance, it is difficult to understand how Blue Shield can argue that article 21.21 applies to The Pharmacy Agreement and its attendant price fixing activities.

Mr. Pogue's testimony reflects the reality of the situation. The Pharmacy Agreement and its attendant price fixing are not within the ambit of article 21.21 because they are not a part of the business of insurance in Texas. It would be highly anomalous for this Court to hold that article 21.21 applies to The Pharmacy Agreement when the State Board of Insurance has manifested a contrary interpretation.

Since the activities challenged herein do not constitute the business of insurance, the potential applicability of the Texas Antitrust Laws to such activities does not invoke the McCarran Act. Where challenged activities do not constitute the "business of insurance", the McCarran Act is inapplicable despite the existence of State legislation proscribing or otherwise regulating them. As one Court recently noted,

> "Even though the Commonwealth [Virginia] may have legislation similar to the Sherman Act and the Clayton Act, the McCarran-Ferguson Act does not oust the Court of jurisdiction unless the activities complained of, though prohibited by State legislation, are . . . a part of the "business of insurance" as defined in *National Securities." American Family Life Assurance Co. v. Planned Marketing Associates, Inc.*, 389 F. Supp. 1141 (E.D. Va. 1974).

Accord, e.g., S.E.C. v. National Securities, Inc., 93 U. S. 453 (1969) (Court held that despite existence of an Arizona statute which regulated the challenged activity, the McCarran Act was nevertheless inapplicable due to the activity's not being the "business of insurance"); *S.E.C. v. Variable Annuity Life Ins. Co.*, 359 U. S. 65 (1959) (holding that challenged activities were not a part of the business of insurance despite fact that the defendants were regulated under the insurance laws of the District of Columbia and several other States; *Center Ins. Agency v. Byers*, 5 CCH

Trade Reg. Rep. ¶ 60,940 at 69,122, 69,123 n. 2 (N. D. Ill. June 10, 1976) (denying application of the McCarran Act despite the fact that the challenged acts were regulated by all states with which they came into contact.)

In their efforts to convince the Court that their challenged activities constitute the business of insurance, Petitioners make the unsupported allegations that "[v]irtually all states regulate . . . [prepaid health plans] under their insurance codes, including special legislation designed to further the states' cost containment objective." Brief for Petitioners at 25. It is true that many states regulate prepaid health plans under their insurance codes, but it is a gross perversion of fact to state that virtually all states have enacted legislation designed to contain costs in provider industries. Petitioners' lack of citation of authorities underscores the falsity of their statement and the inferences intended to be drawn from the statement.

Petitioners fail to inform the Court that despite their regulating nonprofit prepaid health care plans under their insurance codes, many states have stated unequivocally that these plans are not be considered in the "business of insurance." *Se, e.q., ALASKA STAT.* §21.87.060 (providing that "[n]o service corporation may have or use a corporate or business name which includes the words 'insurance,' 'casualty,' 'surety,' 'health' and accident,' 'mutual,' or other terms descriptive of an insurer *or insurance business.*") (emphas added); IDAHO CODE §41-3407 (1977) (stating that "[n]o service corporation shall have or use a corporate or business name which include the words 'insurance,' 'casualty,' 'surety,' 'health and accident,' 'mutual', or other terms descriptive of an insurance *or insurance business business*") (emphasis added); KENTUCKY REV. STAT.

§304.32-060 (1972) (stating that "[t]he name of the corporation shall not include the words 'insurance', 'casualty', 'surety,' 'mutual', or any other words descriptive of the insurance, casualty, or surety business"); MICH. COMPILED LAWS ANN. §550.303 (1967) (stating that the name by which such corporations shall be known is "not to include the words insurance, casualty, surety, health and accident, mutual *or other words descriptive of the insurance and surety business*") (emphasis added); MINN. STAT. ANN. §62C.04 Subd. 3 (Supp. 1977) (stating that "no service plan corporation shall include within its name the 'insurance', 'casualty', 'surety', 'mutual', 'indemnity', or any other words descriptive of the insurance, casualty, or surety business). The states have clearly precluded these nonprofit prepaid health care plans from holding themeselves out as engaged in the business of insurance. The States have wanted to make clear that the mere fact of regulation within the parameters of their insurance codes was not a determination that the entity was engaged in the business of insurance.

II.

THE LACK OF REGULATION BY TEXAS RENDERS PETITIONERS' CHALLENGED ACTIVITIES SUBJECT TO SCRUTINY UNDER THE FEDERAL ANTITRUST LAWS.

In order for an insurance company's activities to have McCarran Act immunity from scrutiny under the federal antitrust laws, the activities must be regulated by the State in addition to their constituting the "business of insurance." *See, e.q., Battle v. Liberty National Life Ins. Co.*, 492 F.2d 39, 49 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110 (1975); *Travelers Ins. Co. v. Blue Cross*, 481 F.2n 80, 82

(3rd Cir.), *cert. denied*, 414 U.S. 1093 (1973). The McCarran Act provides that the Sherman and Clayton Acts "shall be applicable to the business of insurance *to the extent* such business is not regulated by State law." 15 U.S.C §1012(b) (1970). It is not enough for immunity merely that the State regulate the business of insurance in general. That State must regulate the particular challenged activities as part of the business of insurance. Congress carefully provided that the antitrust laws would apply "to the extent" the insurance business is not regulated by State law rather than "if" the insurance business is not regulated by State law. Congress served notice that the mere existence of "some" regulation is not in itself sufficient for immunity.

The McCarran Act renders the antitrust laws inapplicable when State legislation regulates the conduct in question (assuming it is the business of insurance) and authorizes enforcement through a scheme of administrative supervision. *F.T.C. v. National Casualty Company*, 357 U.S. 560 (1958). There is no question that Texas has regulated health and accident insurance to some extent during the period of time relevant to this suit. However, Petitioners particular challenged activities have not ben regulated, and it is the latter regulation that must be present to invoke immunity. The Act's legislative history demonstrates that mere general regulation of the business of insurance by the States was to be insufficient for immunity.

> Senator Barkley: I should like to ask, in this connection, whether, where States attempt to occupy the field — but do it inadequately — by going through the form of legislation so as to deprive the Clayton Act, the Sherman Act, and the other acts of their jurisdiction, it is the Senator's interpretation of the conference report that in a case of that kind, where the legislature fails adequately even to deal with the field it attempts to cover, these acts still would apply?
>
> Senator McCarran: That is my interpretation. 91 CONG. REC. 1444 (1945).

The federal antitrust laws were to remain in effect in a State unless the State enacted "adequate" regulation — regulation of the particular challenged activities.

This test of "adequacy" is carried into the Act by the "to the extent" phrase in the proviso. It requires courts to inquire into the *specific* impact of the State law, not merely to ascertain that some state law concerning the type of insurance involved has been enacted. Congress did not intend that the Act be utilized to institute a system of *private regulation* by insurers with mere tacit approval by the States. Although Congress desired to authorize State supervised rate-seting, it was as opposed to private price-fixing as ever. *See*, in particular, the comments of Senator O'Mahoney, a co-sponsor of the bill, in 91 CONG. REC. 1480, 1483, 1485 and 1486 (1945).

As has been discussed extensively in various contexts throughout the body of this brief, Texas does not regulate Petitioners' challenged activities as a part of the business of insurance. Although Petitioners persistently refer to "aggressive" and "pervasive" regulation of their challenged activities, this Court must not be misled. The entire want of regulation in the area of Petitioners' challenged activities is underscored by the fact that Texas does not even regulate Blue Shield's premium rates to its own subscribers, much less its activities as a private regulator or "container" of prices in the retail pharmaceutical industry. *See* Pogue Depo. at 64. Texas does not regulate the amounts to be paid to providers of benefits under health and accident insurance

policies, which includes Blue Shield's Prescription Drug Insurance Policy. (Pogue Depo. at 59-60). Thus, unlike the situation in *Travelers Ins. Co. v. Blue Cross*, 481 F.2d 80 (3d Cir), *cert. denied*, 414 U.S. 1093 (1973), and *Travelers'* progeny in Pennsylvania, it cannot be argued that Petitioners' challenged activities are being undertaken in response to duress, request, or even simple urging by the Texas Commissioner of Insurance. The Commissioner does not even have authority to regulate Blue Shield's premium rates in Texas, much less urge, tactly approve, or even supervise the entirely private price fixing activities pursued by Blue Shield and the Petitioner pharmacy chains in the retail pharmaceutical industry. Petitioners are acting solely as "volunteers."

Texas' entire want of regulation in the area of Petitioners' challenged activities is further underscored by Petitioners' reference to "special legislation designed to further the states' cost containment objective." Brief for Petitioners at 25. In referring to such legislation, Petitioners fail to cite any authority other than the NAIC Brief. The NAIC Brief cites laws in three States that purportedly "regulate the rate of reimbursement to hospitals." NAIC Brief at 32. What about TEXAS — the state in issue? Where are the TEXAS statutes regulating the rate of reimbursement to *retail pharmacies*? Where are the TEXAS statutes regulating the terms of Blue Shield's contracts with retail pharmacies? There are none! Texas has absolutely no regulation of the business of insurance in the area of Petitioners' challenged activities. Petitioners' challenged activities are entirely unsupervised and unregulated.

Petitioners argue that TEX. INS. CODE ANN. art. 21.21 applies to their challenged activities. Respondents respectfully request that the Court closely scrutinize the provisions of article 21.21. It would certainly be a *tour de force* to find any provisions in article 21.21 that would reach Petitioners' price fixing activities in the retail pharmaceutical industry. As Texas courts have recognzed, articles 21.21 § 4 has as its purpose the prevention of "monopoly or unreasonable restraint in the business of *supplying insurance*." *Russell v. Hartford Casualty Ins. Co.*, 548 S.W.2d 737, 742 (Tex. Civ. App. — Austin 1977, writ ref'd n.r.e.). There is nothing in the statute's language nor in the decisional law interpreting it that remotely suggests the statute would or could reach a conspiracy between an insurer and retail pharmacy chains to fix the retail sales prices of pharmaceuticals. Petitioners' challenged activities constitute a private system of wage and price control in the retail pharmaceutical industry, implemented by entities with overwhelming market power. These activities are being conducted without the safeguards of a state scheme of administrative antitrust laws.

III.

THE EXISTENCE OF BOYCOTT, COERCION, AND INTIMIDATION ELIMINATE THE IMMUNIZING EFFECTS OF THE McCARRAN ACT IN THIS CASE.

In granting a summary judgment for Petitioners, the District Court held that the "boycott, coercion, intimidation" exception in Section 3(b) of the McCarran Act is limited to "the issuance of black-lists naming insurance companies or agents." (App. 112a). Since this case does not involve black-listing of insurers or their agents, the exception was held inapplicable. *Id.* The Fifth Circuit did not address applicability of the boycott, coercion, or intimidation exception due to its finding that Petitioners' challenged activities do not constitute the business of insurance.

Petitioners' challenged activities directed against independent pharmacists who refuse to sign The Pharmacy Agreement and fix their prices at the specified level are deprived of possible McCarran Act immunity by section 3(b) of the Act. 15 U.S.C. §1013(b) (1970). Section 3(b) provides that the Sherman Act remains applicable to an insurers' activities if they constitute "any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation."

The District Court's restrictive reading of section 3(b) was recently rejected by the Court in *St. Paul Fire & Marine Ins. Co. v. Barry*, ... U.S. ..... (June 29, 1978). The reasoning utilized by the Court in holding that the "boycott" exception applies to disputes between policyholders and insurers applies with especial force to disputes between insurers, their provider industry co-conspirators, and providers of goods and services contemplated by the insurance policy. It is not conceivable that the exception protects insurance companies and policyholders from anticompetitive practices, but withholds similar protection from providers of policy benefits who are victimized by private, predatory agreements. Providers are removed from the insurer-policyholder relationship, which the Court recognized as the focus of the Act in *S.E.C. v. National Securities, Inc.*, 393 U.S. 453 (1969).

As has been discussed extensively, Petitioners have conspired to effect a boycott by Blue Shield's subscribers of those independent pharmacists who refuse to fix their retail sales prices at the specified level. The subscriber receives markedly reduced financial benefits and must undergo an administrative burden if he patronizes a pharmacy that has refused to agree on retail sales prices. It is a rare subscriber indeed who is willing to shoulder the extra burdens placed

in his path by Blue Shield in order to patronize the pharmacy of his choice. The success of the boycott is documented in the record. Of the 31,000 claims per month processed by Blue Shield in late 1975, over 98% were for purchases at "participating pharmacies." (Helis Depo. at 10, 13) (App. 281a-282a).

Petitioners coerce and intimidate independent pharmacists to fix their prices at the specified level by withholding from them the patronage of Blue Shield's many subscribers. These activities constitute a form of private economic regulation in the marketplace that, by virtue of the boycott exception, remains subject to scrutiny under the Sherman Act. As the Court observed on pages 14-15 of its *Barry* opinion:

> The debates make clear that the 'boycott' exception was viewed by the Act's proponents as an important safeguard against the danger that insurance companies might take advantage of purely permissive state legislation to establish monopolies and enter into restrictive agreements falling outside the realm of state-supervised cooperative action.

The absence of state-supervision with respect to Petitioners' challenged activities is patent. Petitioners have gone beyond merely taking advantage of permissive State legislation. They have conspired to impose their own brand of private market regulation.

The vice of private government by insurance companies clearly exists in this case. Petitioners' activities unnecessarily penalize pharmacies who refuse to agree on retail prices and thereby stifle competition and the free operation of market forces. As the D.C. Circuit has so ably articulated,

> Such collective use of the insurance companies' power to enforce the terms of a horizontal price-fixing agree-

ment, would thus constitute "boycott, coercion, or intimidation" within the meaning of the boycott provision. *Proctor v. State Farm Mut. Auto. Ins. Co.*, 561 F. 2d 262, 275 (D.C. Cir. 1977), *pet. for cert, pending*, No. 77-580.

Petitioners desire to utilize Blue Shield's power to enforce a horizontal price-fixing agreement among pharmacists. Section 3(b) of the McCarran Act dictates that such activities remain subject to Sherman Act scrutiny.

Petitioners claim they are merely trying to "contain" the cost of pharmaceuticals and thereby keep the cost of insurance premiums at a lower level. Although this professed objective many sound laudible, as it was intended to sound, insurers may not seek to achieve such objectives by conspiring to tamper with the economics of the retail pharmaceutical industry by boycott, coercion, or intimidation, 15 U.S.C. §1013(b) (1970). In the language of the Fourth Circuit, Respondents' complaint, "therefore, alleges conduct that falls within §1013(b) of the McCarran-Ferguson Act subjecting insurance companies, and those who have conspired with them, to the antitrust laws." *Ballard v. Blue Shield of Southern West Virginia, Inc.*, 543 F.2d 1975, 1978 (4th Cir. 1976).

Certainly, if boycotts of insureds are without the McCarran Act as *Barry* held, boycotts, coercion, and intimidation of independent pharmacies by insurance companies and competing pharmacists are even further removed from the Act's immunity and create a clear case justifying application of Section 3(b) of the Act. Indeed, as the court stated at page 20 of *Barry* case:

> "This concerted refusal to deal went well beyond the private agreement to fix rates in terms of coverage, as

> it denied policyholders the benefits of competition in vital matters such as claims policy and *quality of service.*"

Further, as the record demonstrates despite the numerous erroneous statements by Petitioners and their amici, there is no State authorization of the conduct in question.[15] Section 3(b), by its express terms, subjects Petitioners challenged activities to Sherman Act scrutiny.

IV.

SINCE THEY CLEARLY ARE NOT INSURANCE COMPANIES, AND ARE NOT PERFORMING ACTIVITIES CUSTOMARILY UNDERTAKEN BY INSURERS IN THE SALE OR FINANCING OF INSURANCE POLICIES, THE PETITIONER PHARMACY CHAINS CANNOT RELY ON THE McCARRAN ACT TO INSULATE THEIR ACTIVITIES FROM FEDERAL ANTITRUST SCRUTINY.

There can be no doubt that in enacting the McCarran Act, Congress' sole concern and purpose was to exempt *insurance companies*, their agents, and employees from federal regulation with respect to their activities constituting the business of insurance, when such activities are adequately regulated by State law. Congress never contemplated nor intended that the McCarran Act be utilized to insulate from the federal antitrust laws other entities that might deal with insurers in some capacity. The Supreme Court has recognized that Congress intended the Act to be utilized to exempt insurance companies from federal scrutiny with respect to their activities constituting the business of insurance by observing as follows:

> "The McCarran-Ferguson Act was an attempt to turn back the clock, to assure that the *activities of insurance*

[15] Certainly, not *all* actions which could conceivably be authorized by state insurance regulation would necessarily be part of the "business of insurance."

> *companies* in dealing with their policyholders would remain subject to state regulation." *S.E.C. v. National Securities, Inc.*, 393 U. S. 453, 459 (1969) [emphasis added]

Accord, e.g., Meicler v. Aetna Cas. and Surety Co., 506 F.2d 732, 733 (5th Cir. 1975). In drafting the Act, "Congress was mainly concerned with the relationship between insurance ratemaking and the antitrust laws, and with the power of the States to tax *insurance companies*." *S.E.C. v. National Securities, Inc.*, 393 U.S. 453, 458-59 (1969) [emphasis added].

The utilization of the McCarran Act to immunize entities other than insurance companies from the antitrust laws would in no way further the purposes behind the Act. Such application would not assure "that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation." It would not in any way be guaranteeing that State regulation and taxation of insurance companies remain free from federal interference.

The Court has emphasized that the Act is aimed at insurance companies, as contrasted with other entities, which by definition cannot engage in the business of insurance, by observing as follows:

> "*Insurance companies* may do many things which are subject to paramount federal regulation; only when *they* are engaged in the "business of insurance" does the statute apply." 393 U. S. at 459-60 [emphasis added].

Other Courts have joined in this interpretation. *See Pastor v. Hartford Fire Ins. Co.*, 5 CCH Trade Reg. §60,783, at 68,396 (C.D. Calif. March 5, 1976) (holding that the Los Angeles County Medical Association, in allegedly conspiring with insurance companies, was not engaged in the business of insurance and could not rely on the McCarran Act to immunize its conduct); *Center Ins. Agency, Inc. v. Byers*, 5 CCH Trade Reg. §60,940, at 69,122 (N.D. Ill. June 10, 1976) (holding that non-insurance companies cannot be engaged in the business of insurance).

Petitioners argue that by contracting with Blue Shield to provide benefits, the pharmacy chains are engaging in the business of insurance. There are definite conceptual problems with this theory. Its acceptance leads to the conclusion that a pharmaceutical distributor is engaged in the "practice of medicine" if it sells antibiotics to a physician for administration by the physician in his office. After all, the physician is obviously engaged in the practice of medicine when he administers an injectable antibiotic. Utilizing Petitioners' reasoning, we must conclude that the pharmaceutical distributor has become an "integral part" of the physicians' practice of medicine since it has "contractually agreed with" the physician to provide the substance that he has agreed to administer to his patient. The unacceptability of this reasoning is no less in the context of a pharmacy's being engaged in the "business of insurance".

Although the Seventh Circuit in *Lowe v. Aarco-American Inc.*, 536 F.2d. 1160 (7th Cir. 1976), did cloak two non-insurance company defendants with McCarran Act immunity concerning alleged violations of the Truth in Lending Act, the holding of that case is much narrower than Defendants imply. The defendants were an insurance broker and a premium finance company. They were sued for alleged violations of the Truth in Lending Act that allegedly occurred in their credit sales of insurance policies. The Seventh Circuit correctly held that the credit sales of insurance

policies are part of the business of insurance and correctly invoked McCarran Act immunity. Although the two defendants in *Lowe* were not insurance companies, they were performing activities customarily performed by insurers. One defendant sold automobile insurance policies and the other defendant financed the premiums required under those policies. In this regard they could be viewed as extensions of the insurance company. The Seventh Circuit expressly noted that Illinois regulates premium finance companies under the Illinois Insurance Code.

The Petitioner pharmacy chains herein, unlike the defendants in *Lowe*, are not performing activities customarily performed by insurers. Neither the sale of pharmaceuticals nor the fixing of prices in the pharmaceutical industry are customary activities of insurance companies, and the Petitioner pharmacy chains cannot by virtue of their price fixing activities be considered extensions of an insurance company. *Lowe* serves as no precedent for the extension of the McCarran Act to the activities of the Petitioner pharmacy chains in conspiring and agreeing to fix prices.

The liberal interpretation that the Petitioners place on the exemption afforded by the McCarran Act conflicts with the Court's admonition that "there is a heavy presumption against implicit]antitrust[exemptions." *Abbott Lab. v. Portland Retail Druggists Ass'n, Inc.*, 425 U.S. 1, 12 (1976), *quoting Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787 (1975). Since the McCarran Act operates in derogation of the federal antitrust laws, it is to be strictly construed. *American General Ins. Co. v. F.T.C.*, 359 F. Supp. 887, 894 (S.D. Tex. 1973), *aff'd*, 496 F.2d. 197 (5th Cir. 1974). There is absolutely no indication that either Congress in drafting the McCarran Act, nor the Court in interpreting it, entertained the idea that the Act would or could apply

to entities other than insurance companies and their agents or employees. In th absence of such an indication, utilization of the McCarran Act to insulate the Petitioner pharmacy chains' conduct from antitrust scrutiny constitutes an unwarranted expansion of the act at the expense of the federal antitrust laws.

If the Petitioner pharmacy chains' activities are subjected to scrutiny under the antitrust laws, the thrust of the McCarran Act would in no way be violated. It could not be argued that such action would serve to "invalidate, impair or supersede any law enacted by . . . [the State of Texas] for the purpose of regulating the business of insurance." *See* 15 U.S.C. §1012(b) (1970). The uncontradicted evidence demonstrates that the Texas State Department of Insurance has no jurisdiction or regulatory authority over pharmacies (Pogue Depo. at 53, App. 339a) even though the Texas legislature has given the Department "regulatory authority over anything that encompasses insurance in the State of Texas." (Pogue Depo. at 66, App. 345a). Application of the antitrust laws to Petitioner pharmacy chains, then, would not interfere with the administration of any Texas statute regulating the business of insurance.

Even if Blue Shield were able to immunize itself from the federal antitrust laws with respect to the activities challenged herein through reliance on the McCarran Act, the Petitioner pharmacy chains could be held accountable under the antitrust laws for their activities in combining and conspiring with Blue Shield and each other. The McCarran Act, where applicable, merely immunizes an insurance company from the regulatory control of federal statues for its conduct constituting the business of insurance; it removes federal jurisdiction over the insurer with respect to

such activity. The McCarran Act does not, however, in any way declare the insurer's activity to be legal or to be in compliance with the federal antitrust laws.

Inability to maintain an antitrust suit against an insurance company for its activities consitituting the business of insurance, due to the insurer's jurisdictional immunity for such activities, does not prevent maintenance of an antitrust action against a non insurance company co-conspirator who does not, by definition, fall within the ambit of the McCarran Act. The situation is analogous to that involving an illegal combination or conspiracy between a domestic and a foreign corporation.

The Supreme Court has long recognized that inability to obtain jurisdiction over, or enforce a judgment against one party to an illegal combination or conspiracy does not free the other party from application of the federal antitrust laws. *See e.g., Timken Roller Bearing Company v. United States*, 341 U.S. 593 (1951) (upholding jurisdiction in a civil antitrust action charging Timken Roller Bearing Co., an Ohio corporation, with violations of the Sherman Act in combining and conspiring with British Timken, Ltd. and with Societe Anonyme Francioise Timken to restrain interstate and foreign commerce). The situation is also analogous to that involving a domestic corporation that has acted as the agent of a foreign nation that is not within the jurisdiction of the United States district courts due to sovereign immunity. The Supreme Court has held that immunity cannot be claimed by or on behalf of a domestic corporation merely because it was acting as the instrumentality or agent of a government that is itself immune from suit. *See e.g., Sloan Shipyards Corp. v. United States Shipping Board Emergency Fleet Corp.*, 258 U.S. 549, 567

(1939). Petitioners Rieger, Sommers, and Walgreens are likewise precluded from relying on any McCarran Act immunity that Blue Shield might have to escape application of the federal antitrust laws.

There is an additional and controlling reason why the Fifth Circuit's decision must be affirmed as to Rieger, Sommers and Walgreens. Their activities as challenged herein are not confined to acts of combination and conspiracy with Blue Shield. The Petitioner pharmacy chains have also combined and conspired with each other to fix the retail sales prices for pharmaceuticals and to foreclose Respondents from a substantial portion of the market for prescription pharmaceuticals. The McCarran Act can have no possible applicability to such acts.

CONCLUSION

A central purpose of the antitrust laws is the promotion and preservation of marketplaces in which consumers are provided choices or options in terms of the prices, quality and services associated with the products they purchase. Petitioners' challenged conduct strikes at the very basis of the federal antitrust laws and at the heart of the small businessman.

It is crucial that this Court refuse to expand the McCarran Act exemption so as to give insurers blanket antitrust immunity for all their activities in combining and conspiring with those persons or entities selling the goods and services purchased with proceeds of insurance. The threat to our free market economy that such blanket exemption would present is staggering and is best described

by the Court's own recent language in a non-insurance context:

> "[T]hese bodies . . . [insurers] are fully capable of aggrandizing other economic units with which they interrelate, with the potential of serious distortion of the rational and efficient allocation of resources, and the efficiency of free markets which the regime of competition in the antitrust laws is thought to engender. If . . . [insurance companies and the large providers of policy benefits acting in concert] were free to make economic choices counseled solely by their own parochial interests and without regard to their anticompetitive effects, a serious chink in the armor of antitrust protection would be introduced at odds with the comprehensive national policy Congress established." *City of Lafayette v. Louisiana Power & Light Co.*, ——— U.S. ———, 98 S. Ct. 1123, 1134 (1976).

This Court must not allow the wholesale abandonment of the federal antitrust laws urged by Petitioners. The decision by the United States Court of Appeals for the Fifth Circuit should be affirmed and this cause should be remanded for a trial on the merits.

Respectfully submitted,

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APPENDIX A

May 28, 1968

Mr. Tom L. Beauchamp, Jr., President
Group Life & Health Insurance Co.
Main at North Central Expressway
Dallas, Texas 75222

Re: Drug Program — Indemnity Areas

Dear Tom:

For areas like yours who are faced with the auto "service" drug program, I have a germ of an idea (which you may have already discarded) hinged mainly on providing a greater indemnity to pharmacies (acquisition cost plus dispensing fee) because of agreement to use a "bulk or simplified" accounting base; i.e., more benefit because of lesser administrative cost. The mass accounting agreement would then serve like a participating agreement.

1. On the subscriber contract the indemnity would be 75% of usual and customary, subject to the provision that Blue Shield, under a facility of payment clause, shall extend indemnity, to the extent that a subscriber need pay no more than the deductible for such item, for drugs billed for by and payable to all pharmacies agreeing to Blue Shield's mass claims accounting agreement, as may be established by Blue Shield.

   The basic claims payment clause would be to pay the subscriber or, by using a facility of payment clause, the pharmacy. The company's option to use the facility of payment clause would uniformly be for those pharmacies having a mass accounting agreement. I think it would be best to draft the contract so that the Insurance Board would require filing of the mass accounting agreement to strengthen your base on anti-trust. Drafting problems will get sticky here, but let's pass on that for now.

2. The mass accounting agreement probably should have self-service whereas clauses emphasizing Blue Shield's intent to offer coverage, desire to relate payments to

providers for these services, and the need to simplify administration and accounting in the public interest. The basic agreement would be that the accounting basis of indemnification under the facility of payment clause of the subscriber contract, for Blue Shield subscribers for service rendered by the pharmacy, would be acquisition cost plus dispensing fee in the aggregate for all services within a reporting period and that the pharmacy would make no charge to the subscriber in excess of the deductible. The pharmacy's quid pro quo is "averaging", bulk submissions and payment to him.

Tom, there are a lot of holes in this, but the alternative is paying usual and customary — and praying.

Sincerely,

Marv

M. C. Reiter

FOR ARGUMENT

Supreme Court, U. S.
FILED
OCT 2 1978
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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REPLY BRIEF FOR PETITIONERS

SUMMARY OF ARGUMENT

The sole issue in this case is whether the statutory term "business of insurance," as contained in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-13 (1976) ("McCarran Act"), includes a contract between an insurer and a health care provider to furnish benefits owed to policyholders under the insurer's health care service

benefit policies. In petitioners' initial brief, as well as those of the numerous *amici curiae* in support of reversal, it was fully demonstrated that the Pharmacy Agreement here in issue is functionally inseparable from the insurer-policyholder contract and, therefore, a part of the "business of insurance."

In support of the result reached below, however, the United States as *amicus curiae* seeks to blur the clear-cut distinction between Blue Shield's Pharmacy Agreement and other types of agreements between insurers and non-insurers. The Pharmacy Agreement is not merely a device to contain claims costs and thus reduce rates, as the government contends, although that is an important feature. Rather, the Agreement is the means by which Blue Shield fulfills its basic obligation to furnish policy benefits to its insureds in the form of goods and services rather than cash. The Pharmacy Agreement thus fits within this Court's definition of insurance as a "*guarantee* that at least some fraction of the benefits will be payable in fixed amounts." *Securities and Exchange Commission* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65, 71 (1959) (emphasis added). The Pharmacy Agreement, moreover, is so necessary to the "type of policy" issued and its enforcement and reliability as to bring it within the "business of insurance." *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969).

Service benefit insurance plans utilizing provider agreements are a distinctive characteristic of the health insurance industry. In contrast to the risks covered by most other types of insurance, medical care is a necessity and the policyholder is therefore vitally interested in receiving full coverage. Health insurers such as Blue Shield have met this policyholder need and have alleviated the financial concerns of insureds by offering coverage in the form of goods and services rather than cash reimbursement, and by assuming the responsibility of paying

for policy benefits. As evidenced by more than twenty state enabling statutes enacted in the 1930s, health service benefit plans are a type of insurance which predated the McCarran Act, and which were in the contemplation of Congress when the Act was passed.

Because the objective of the Pharmacy Agreement is to furnish to insureds the goods and services which are the precise benefits the policy guarantees, the Agreement is far different in concept and operation from other types of agreements between insurers and non-insurers unrelated to the obligation to provide benefits. For this reason, the government is wide of the mark in asserting that petitioners would define the "business of insurance" to include (1) any agreement between insurers and others to lower expenses which might ultimately be reflected in lower premiums or greater solvency, or (2) any agreement to supply insurers (rather than policyholders) with goods and services not comprising policy benefits.

While Blue Shield's Pharmacy Agreements are within the "business of insurance" without the need to inquire into their impact on rates, that impact is an independent ground for finding them to be within the "business of insurance". The government's characterization of effect on rates and solvency as immaterial for purposes of the McCarran Act ignores one of the primary purposes of the Act, to preserve state regulation directed at rate-making and solvency. *Securities and Exchange Commission* v. *National Securities, Inc.*, *supra*, 393 U.S. at 460. The effect of the Pharmacy Agreement on rates and solvency is hardly minimal. The Agreement does not seek to contain the costs of Blue Shield's incidental expenses but the costs of the very goods and services whose purchase is the risk assumed in the contract of insurance. The Agreement is thus an integral part of the rate-making process since rates are principally dependent upon loss experience.

Tacitly repudiating the *National Securities* definition of the insurance business as including the type of policy

issued, its reliability and enforcement, as well as other activities directly affecting rates and solvency, the government proposes new standards, none of which would effectuate the intent of the Act:

1. The government exhibits a fundamental misunderstanding of the insurance business when it attempts to draw a distinction between "risk underwriting" or "risk spreading" and "risk reduction", with so-called "risk spreading" identified as the sole function of insurers and the Pharmacy Agreement categorized as a "risk reduction" device. (Brief for the United States as *Amicus Curiae* ("U.S. Br.") at 15-19) The process of assessing risks in order to determine what obligations an insurer will assume—a process fundamental to the insurance business—necessarily entails efforts to reduce risks and to make them more readily predictable, as Congress recognized when it passed the McCarran Act. Blue Shield's decision to limit the magnitude of the risk covered by the policy and to make it more predictable by means of the Pharmacy Agreement is thus an essential part of the insurer's function, whether it be described as "risk spreading" or "risk reduction". The government, indeed, elsewhere acknowledges that the "formula for the payment of insurance claims"—such as the reimbursement formula contained in the Pharmacy Agreement—"is an integral part of any contract of insurance, because it determines how much risk is involved, and how much of the risk will be assumed by the insurer." (U.S. Br. at 31)

2. The government also misreads the McCarran Act in proposing to immunize horizontal agreements among insurers but not vertical agreements between insurers and health care providers entered into for the sole purpose of furnishing the benefits specified in the insurance policy. (U.S. Br. at 30-33) This standard was rejected by Congress when it refused to limit the exemption to such horizontal activities as rate bureaus and risk-pooling. In terms

of the impact on the policyholder, Blue Shield's arrangements with pharmacies have a much more direct and profound effect than some horizontal arrangements which the government admits to be part of the insurance business, but which affect the insured only indirectly (*e.g.*, insurance association membership rules).

Taking a different approach from that of the government, respondents contend that only those provider agreements having anticompetitive effects are not a part of the "business of insurance". (Brief for Respondents ("Resp. Br.") at 33-35) However, as the government emphasizes (U.S. Br. at 10), this argument confuses the immunity issue with substantive questions of antitrust law, and would neutralize the central purpose of the McCarran Act to exempt activity which might otherwise violate the antitrust laws. Respondents also misconstrue the Act in contending that it was not intended to immunize the acts of non-insurance companies. Unlike other express antitrust exemptions based on the identity of the potential recipient, the McCarran Act, by referring to the "business of insurance" and "every person engaged therein" rather than to "insurance companies", is conduct-oriented. Since the Pharmacy Agreement is conduct within the "business of insurance," both signatories necessarily must be immune to effectuate the Act's purposes.

As an express immunity unique among the federal antitrust exemptions in its subordination of federal regulation to regulation by the states, the Act should be liberally construed to carry out the Congressional purpose. To the extent that respondents, the government or others feel that federal antitrust regulation should supplant regulation by state administrators, it is the province of Congress and not the courts to make any such fundamental alteration.

ARGUMENT

I. AS AN EXPRESS EXEMPTION INCORPORATING THE PRINCIPLE OF COMITY BETWEEN THE FEDERAL GOVERNMENT AND THE STATES, THE McCARRAN ACT SHOULD BE CONSTRUED SO AS TO GIVE EFFECT TO ITS POLICY OF DEFERRING TO STATE REGULATION

Underlying the government's view of this controversy is its mistaken equation of the McCarran Act with other antitrust exemptions established, not by act of Congress, but by the judiciary as a means of reconciling competing regulatory policies. (U.S. Br. at 15) The government would thus erroneously apply the heavy presumption against *implied* antitrust immunities to construe the Act narrowly. (*Id.*) The McCarran Act, however, is an *express* exemption enacted in recognition of the special characteristics of the insurance industry.[1] Alone among the express exemptions, the purpose of the McCarran Act is to forego federal regulation (except in cases of boycott) in deference to regulation by the states. In view of the declared policy of Congress, the Act should not be read to grant antitrust immunity only to the extent necessary to obviate direct conflict with the antitrust laws, but rather should be interpreted liberally to carry out the Congressional intent. The term "business of insurance" should therefore be construed so as to effectuate Congress' policy of federal abstention where the states have undertaken to regulate the "business of insurance."

To the extent that it is felt (as the government apparently does) that federal antitrust regulation would benefit policyholders and health care providers more than regulation by state administrators, it is the province of Congress

[1] *See* National Society of Professional Engineers v. United States, 98 S. Ct. 1355, 1364, n. 14 (1978).

and not the courts to make any such fundamental alteration.[2] The legislative process, able to range beyond the narrow facts of this case and providing an opportunity for the states and consumers as well as health care providers and insurers to present their views, is the proper vehicle for resolving any policy decisions on the best form of regulation for the health insurance industry.[3]

[2] For these reasons, the government is incorrect in arguing that the "business of insurance" should be narrowly construed in cases of doubt because of the possibility that state regulation may not be effective. (U.S. Br. at 27, n.15) While the lower courts have generally refused to inquire into the efficacy of a state's chosen scheme of regulation (as the government notes, U.S. Br. at 27), this Court has indicated that the exemption will not be available where state regulation is a "pretense." *See* FTC v. National Casualty Co., 357 U.S. 560, 564 (1958). The government's presumption that state regulation would be less effective than federal antitrust regulation is also open to substantial question. Most states (like Texas) require prior approval of all new policy forms, and many also regulate rates. These comprehensive forms of regulation can be viewed as much more effective than hit-or-miss antitrust regulation left to the discretion of prosecutors and private plaintiffs. Additionally, virtually every state has adopted unfair trade practices legislation applicable to the insurance industry, protecting consumers against anticompetitive or deceptive practices to a degree far more specific than the general prohibitions of the federal antitrust laws.

[3] Both Congress and the Executive Branch are now considering proposals for possible modification of the McCarran Act. The National Commission for the Review of the Antitrust Laws, comprised of representatives from Congress, the judiciary, the Antitrust Division of the Department of Justice and the Federal Trade Commission, is undertaking a study of the McCarran Act exemption and will report its conclusions, including any recommended legislative changes, in December, 1978. In addition, the House Small Business Subcommittee on Capital, Investment and Business Opportunities is now considering a series of options concerning the McCarran Act. The National Underwriter, August 18, 1978, at 1.

II. THE "BUSINESS OF INSURANCE" INCLUDES BLUE SHIELD'S PHARMACY AGREEMENT BECAUSE IT IS AN INTEGRAL PART OF BLUE SHIELD'S CONTRACTUAL OBLIGATION TO PROVIDE BENEFITS TO ITS POLICYHOLDERS IN THE FORM OF GOODS AND SERVICES, RATHER THAN CASH

Ignoring the history and rationale of the prepaid health plan's tripartite method of delivering health insurance benefits in the form of services to the insured, the government argues that all provider agreements should be excluded from the "business of insurance" because petitioners propose an allegedly limitless definition of the term. The government warns that acceptance of petitioners' interpretation of the "business of insurance" would lead to expansion of that business to include: "[e]verything an insurance company does to make money or to reduce its costs . . ." (U.S. Br. at 8, 17-18); every contract between an insurer and a supplier of goods or services (U.S. Br. at 18); and every activity of an insurer which could be said to have the slightest impact on premium rates or benefits. (U.S. Br. at 27-28, 32) Because the government fails to recognize the distinctive characteristics of the kind of provider agreement long utilized by prepaid health service benefit plans, these predictions are groundless. More significantly, outright exclusion of all provider agreements from the insurance business would unrealistically confine that business to the delivery of cash benefits only.

Blue Shield's prescription drug benefit plan involves a tripartite arrangement between the policyholder, the insurer and the health care provider whereby: (1) the insurer receives regular payments from policyholders; (2) the policyholders receive needed prescription drugs from pharmacies; and (3) the pharmacies agree to accept payment from Blue Shield (plus a small payment in the

amount of the policy deductible, or less, from the insured) as full payment for the goods and services rendered to the policyholders.

The government's fundamental misconception of this insurance plan is that the Pharmacy Agreement is merely a means of reducing the cost of claims. While it is that, it is at the same time much more. As the district court found (App. 107a), the Pharmacy Agreement is the "business of insurance" because it is the essential *means* by which Blue Shield fulfills its basic obligation to furnish policy benefits in the form of goods and services rather than cash. Since the Agreement is the method of implementing the service benefit form of insurance, neither the policy nor the Agreement is operable without the other and together they constitute a unified plan of insurance.[4] The goods and services provided through the Pharmacy Agreement are, in short, the precise benefits which the policy promises to the insured.

The unity of the Pharmacy Agreement and the benefit provisions of the insurance policy is fully consistent with this Court's definition of insurance—in a case heavily relied upon by the government—as a "*guarantee* that at least some fraction of the *benefits* will be payable in fixed amounts." *Securities and Exchange Commission* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65, 71 (1959) (emphasis added). Blue Shield's "guarantee" that its insureds receive the benefits specified in the prescription drug policy is effectuated through the Pharmacy Agreement.

This tripartite structure of health service benefit insurance distinguishes the provider agreement from other

---

[4] For the reasons discussed above, the government seriously understates the nature and express terms of the policy (*see* App. 54a-55a) when it contends that the policy only "implicitly" contemplates participating pharmacy agreements. (U.S. Br. at 28, n.16)

types of agreements between insurers and non-insurers. While, to use the government's hypotheticals (U.S. Br. at 18), an insurer might seek to limit expenses and reduce rates by contracting with a printer or a building owner to reduce printing costs or building rentals, such agreements do not constitute the fulfillment of the basic policy obligation to furnish benefits. Nor would satisfaction of that obligation be entailed in an insurer's agreement with an automobile manufacturer to install specially-designed bumpers on all cars. (U.S. Br. at 17-18) Indeed, even a requirement in the policy that the insurer enter into agreements to contain costs unrelated to benefits would be distinguishable from Blue Shield's Pharmacy Agreement, since the former would not relate to the furnishing of policy benefits.[5]

Further, contrary to the government's suggestion (U.S. Br. at 18), an agreement between an insurer and a supplier of goods or services to the *insurer* would not necessarily be included within the "business of insurance" because, among other things, such agreements do not deliver promised benefits directly to the insured.

The government's conception of the "business of insurance" also suffers from a wholly impracticable bifurcation between the contract with the policyholder and its method of implementation and settlement of claims. To exclude the Pharmacy Agreement would reduce Blue Shield's prescription drug insurance plan to unenforceable contracts, even though *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969), explicitly identified the enforcement and reliability of policies as part of the "business of insurance."

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[5] Consequently, Blue Shield does not argue, as the government implies (U.S. Br. at 28, n.16), that the "mere reference" to the Pharmacy Agreement in the insurance policy is, standing alone, sufficient to immunize the agreement.

The government's unqualified exclusion of *all* provider agreements from the "business of insurance" would, in fact, limit that business to cash benefits only. Since provider agreements are indispensable to the delivery of service benefits to the insured, exclusion of such agreements from the "business of insurance" would necessarily result in the exclusion of the delivery of service benefits from the business. Such a myopic, unprecedented view of the "business of insurance" ignores the development of the entire prepaid health plan sector of the health insurance industry. Moreover, exclusion of the essence of the prepaid health plan's business—delivery of service benefits—from the "business of insurance" would contradict the Solicitor General's own admission that the "view" that "prepaid health plans are the business of insurance" is "not now in dispute." (U.S. Br. at 25, n.13) Exclusion of service benefits from the insurance business would also conflict with the government's concession that the method of policy implementation and claims settlement is functionally inseparable from the policy:

> The formula for the payment of insurance claims is an *integral part of any contract of insurance*, because it determines how much risk in involved, and how much of the risk will be assumed by the insurer. Such agreements among insurers *are no different in substance from agreements on the premiums to be charged* . . . . [U.S. Br. at 31 (emphasis added)]

In ignoring the linkage between the provider agreement and the policy benefits, both the government and respondents take a parochial and unrealistic view of what is of concern to policyholders. Rather than being of only ancillary importance to the insured, the provider agreement is one of the critical features demanded by policyholders who desire the service benefit form of coverage. The importance to insureds of the provider feature is best demonstrated by the fact that the insurance plan before this Court was conceived and initiated by policyholders

and beneficiaries (*i.e.*, the auto companies and U.A.W. members, respectively), not by Blue Shield or the pharmacies. *See* Brief for Motor Vehicle Manufacturers' Association as *Amicus Curiae*, at 11-12.

The tripartite structure of Blue Shield's prescription drug program is a direct response to the relative inelasticity of demand for medical services. Medical care is a necessity:

> A can cannot lose a better job than he holds nor can fire destroy a better house or automobile than he owns. But sickness may require service involving expenditures larger than a man's whole income during the period of disability or the rest of his life, and greater than his entire savings from previous income or gifts. The sick man's need is adequate health service, not a stated amount of cash.

Rorem, *Nonprofit Hospital Service Plans*, 1 Medical Care 135, 139 (1941). A promise from the insurer to pay specified cash benefits to the insured *after* he incurs health care expenses obviously does little to meet the insured's immediate need for services. Absent assurance of service benefits which the provider agreement enables the insurer to provide, the insured may be totally deprived of health care if the health care provider is not satisfied with the current financial status of the insured.

Full-coverage provider agreements, such as the ones involved in this case, eliminate these financial concerns of the insured by transferring the primary payment responsibility from the insured to the insurer. The insured can depend on receiving required health care services without regard to his ability to pay for the services directly. The distinctive tripartite relationship among insured, insurer and health care provider is therefore designed to respond to the three fundamental elements of the demand for health insurance benefits: (1) delivery

of benefits in the form of health care services; (2) transfer of the responsibility of fully paying for the services from the insured to the insurer; and (3) delivery of health care services at costs which are controllable and reasonably predictable to the insurer and the insured.

Prepaid service benefit insurance policies implemented through provider agreements were originated by Blue Shield and Blue Cross Plans before passage of the McCarran Act and have been an established part of the business of insurance ever since. Until the development of service benefits programs during the 1930s, the availability of health insurance was limited, and the insurance which was available paid limited cash benefits which often left the patient with substantial additional expenses at the time of illness and the providers without payment. I. S. Falk, *The Costs of Medical Care* 451-52 (1933).

Blue Cross Plans pioneered the development of the service benefit form of insurance to fill the gap left by the reluctance of commercial insurers to offer service rather than dollar benefits. D. M. MacIntyre, *Voluntary Health Insurance and Rate Making* 124 (1962). The rapid growth of enrollment in hospital service plans, from 200,000 subscribers in 1933 to four million in 1940, demonstrated "the demand for security against the unpredictable expense of health service." Norby, *Hospital Service Plans: Their Contract Provisions and Administrative Procedures*, 6 Law & Contemp. Probl. 545, 557 (1939).

The growth of non-profit hospital services plans based on contracts with providers was facilitated by the passage of enabling legislation which recognized the tripartite arrangement as a necessary and special type of insurance. Rorem, *Enabling Legislation for Non-Profit Hospital Service Plans*, 6 Law & Contemp. Probl. 528, 530, 534 (1939). Between 1934 and 1939, 24 states enacted leg-

islation modeled after the first statute, adopted in New York. *Id.* at 532.[6]

The hospital service plans were followed by the development of comparable tripartite service benefit plans for physicians' services. One of the first of these, the California Physicians Service ("CPS"), which later became a Blue Shield Plan, was incorporated in 1939. J. W. Garbarino, *Health Plans and Collective Bargaining* 108-09 (1960). Like prepaid hospital service plans, prepaid physicians' service plans were dependent upon agreements with participating physicians to fulfill the plans' obligation to provide services to subscribers. Burns, *The Michigan Enabling Act for Non-Profit Medical Care Plans*, 6 Law & Contemp. Probl. 559, 562 (1939). By 1944, when Attorney General Biddle testified before the joint Senate-House subcommittees considering passage of the McCarran Act,[7] tripartite prepaid health insurance plans were flourishing.

The government does not deny that service benefit policies were in widespread use prior to 1945 but resists the idea that these plans had been brought to Congress' attention. The case upon which the Attorney General's testimony was based, however, *American Medical Association* v. *United States*, 317 U.S. 519 (1943), involved the same sort of three-cornered service benefit plan as is present in this case. The insurer, Group Health, had contracted with its subscribers to provide benefits in the form of physicians' services. Group Health had then entered into agreements with doctors to render the services

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[6] *See also* the description of the Pennsylvania Nonprofit Hospital Plan Act of 1937 in Travelers Insurance Co. v. Blue Cross of Western Pennsylvania, 361 F. Supp. 774 (W.D. Pa. 1972), *aff'd*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973).

[7] Joint Hearing before the Subcommittees of the Committees on the Judiciary on S. 1362, H.R. 3269 and H.R. 3270, 78th Cong., 1st Sess. at 41 (1944).

covered by the policies. These agreements were identical in concept to Blue Shield's Pharmacy Agreements. The government, accordingly, is incorrect in concluding that the Attorney General's testimony related "only to prepaid health plans" and not to provider agreements. (U.S. Br. at 25, n.13; *see also* Resp. Br. at 69-70)

Even absent the Attorney General's testimony,[8] it is wholly unlikely that Congress was unaware of the widespread use of Blue Shield and Blue Cross service benefit plans. Certainly there is no indication in the legislative history that Congress intended to define the "business of insurance" in a manner inconsistent with its "customary understanding . . . at the time of enactment," that is, the state of the industry at the time of the Act's passage. *St. Paul Fire & Marine Insurance Co.* v. *Barry*, 46 U.S.L.W. 4971, 4975 (U.S. June 29, 1978).

The government's strained interpretations of the legislative history to the contrary are not persuasive. Congressional definitions of insurance emphasizing the insurer's lack of control over cost factors are not, as the government implies (U.S. Br. at 23, n.10), an indication that Congress intended to protect solely the risk-assuming function, but only reflect the obvious fact that assumption of risk was the special characteristic of the industry. Indeed, an important goal of the Act was to encourage more accurate assessment of costs and reduction of premiums by permitting "agreement[s] in advance" so that an insurer would know "what the terms of its obligation would be" and could estimate cost "factors, in their bearing upon rates and forms of policies . . . with a great reduction in expense." H.R. Rep. No. 873, 78th Cong., 1st Sess. at 9 (1943).

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[8] The Attorney General was not merely expressing his personal opinion, for, as he remarked, "the *Supreme Court* has . . . conceived of [the Group Health plan] as insurance." *Id.* at 42 (emphasis added).

While Congress understandably focused on rate-making and pooling of risk (*see* U.S. Br. at 24), since those practices were the subject of *United States* v. *Southeastern Underwriters Association*, 322 U.S. 533 (1944), Congress rejected language confining the exemption to those and related practices. *See, e.g.*, 79 Cong. Rec. 1444 (1945) (dialogue between Senators Pepper and O'Mahoney); H.R. 4444, 78th Cong., 2d Sess. at 2 (1944) and S. 12, 79th Cong., 1st Sess. at 3 (1945) (both limiting the exemption to specified agreements "between two or more insurance companies" where "expressly approved" by the state in advance). Similarly confining language (referred to by the government, U.S. Br. at 24-25) appeared in an early draft of the McCarran Act prepared by the National Association of Insurance Commissioners. The rejection of these specifically-worded provisions in favor of more general and inclusive language logically leads not to the conclusion drawn by the government, that only "the pooling of risks and the sale of policies" are covered by the Act (U.S. Br. at 24), but rather to the opposite conclusion that Congress intended for the exemption to be more broadly applicable.[9]

In view of the McCarran authors' deep concern over fostering insurance availability at reasonable rates,[10] they cannot have intended a construction of the Act that

[9] The government's references to rejection of language broader than that finally adopted (U.S. Br. at 23) are inapposite to the issue in this case. The phrase "acts in the conduct of [the insurance] business" was eliminated in conference without reference in the conference report, apparently because it was thought duplicative of the term "business of insurance." H.R. 3269, H.R. 3270 and S. 1362 were not rejected in favor of S. 340 and H.R. 1973 (the bills which, as amended, became the Act) because of any decision to narrow the scope of the activities to be exempted, but because Congress determined that the business of insurance should be exempted only in cases of state regulation rather than unconditionally.

[10] *See, e.g.*, H.R. Rep. No. 873, 78th Cong., 1st Sess. at 8, 9 (1943).

would inhibit or penalize the adoption of methods to provide comprehensive coverage at affordable rates. Prepaid health insurance programs arose out of the perilous financial circumstances of individuals during the Depression. H. E. Klarman, *The Economics of Hospital Service*, 29 Harv. Bus. Rev. 71, 78 (1951). However, the unique characteristics of tripartite service benefit plans are equally important in today's inflationary environment because they protect subscribers from the dual risks of illness and escalating prices. H. E. Klarman, *The Economics of Health* 38 (1965). Agreements with providers are the means by which Blue Shield predicts and controls the costs of delivering the promised prescription drug benefits, while continuing to offer competitively priced service benefit contracts demanded by consumers.

In sum, agreements with providers to furnish the goods and services specified as benefits in the insurer-policyholder contract are so closely related to the "type of policy" issued and so necessary to its reliability and enforcement, *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969), as to bring them within the "business of insurance."

III. BLUE SHIELD'S PHARMACY AGREEMENT IS ALSO THE "BUSINESS OF INSURANCE" BECAUSE IT DETERMINES THE COSTS OF THE RISK UNDERWRITTEN

Because Blue Shield's Pharmacy Agreement is an integral part of a service benefit insurance plan, it is the "business of insurance" whether or not it has a substantial impact on rates. Nevertheless, the role of the Pharmacy Agreement in determining rates and preserving Blue Shield's solvency is an important, independent reason why the Agreement constitutes part of the insurance business. The government's attempt to minimize the consequences of the Pharmacy Agreement for Blue Shield's

rate-making and reliability ignores the functional relationship between rates and the cost of benefits.

A leading concern of the authors of the McCarran Act was the effect unrestrained competition might have on rate adequacy and insurer solvency.[11] The McCarran Act was therefore intended to immunize "rate-making" and "other activities of insurance companies" closely relating "to their status as reliable insurers." *Securities and Exchange Commission* v. *National Securities, Inc., supra,* 393 U.S. at 460. The foundation of insurer reliability is, of course, solvency, primarily maintained by setting rates at levels sufficient to cover expected losses. This does not suggest that any and all action by an insurer affecting its rates and financial stability is the "business of insurance," but only recognizes that Congress' and this Court's emphasis on solvency was not mere surplusage, as the government apparently feels. (U.S. Br. at 27-30)

Agreements which contain the costs of the risks covered by the policy should be distinguished sharply from incidental efforts to reduce an insurer's non-claims expenses (such as executives' salaries, or the "printing costs" and "building rental" hypotheticals mentioned by the government). (U.S. Br. at 18) This distinction is based on the truism that insurance rates are a direct function of loss experience. The most important objective in rate-making is to set rates at levels which are predicted to generate sufficient premium income to pay for the losses arising from the risk covered in the policy. As a result, in determining the rates it will charge for its prescription drug policies, the predominant factor considered by Blue Shield is the cost of the prescription drugs whose purchase is the only risk underwritten by the policy.

Because of the interdependence of rates and the cost of drugs, Blue Shield's agreements with pharmacies estab-

[11] *See* H.R. Rep. No. 873, 78th Cong., 1st Sess. at 9 (1943); S. Rep. No. 1112, 78th Cong., 2d Sess. at 6 (1944).

lishing the formula determining those costs necessarily has a substantial impact on rates. Apart from its causal relationship to rates, the formula for drug costs contained in the Pharmacy Agreement is crucial because in large part it determines the magnitude of the risk assumed by the insurer. The interrelationship of reimbursement formulas, rates and assumption of risk is, indeed, acknowledged by the government. (U.S. Br. at 31)

IV. THE GOVERNMENT'S RISK "UNDERWRITING" VERSUS RISK "REDUCTION" COMPARISON IS A DISTINCTION WITHOUT A DIFFERENCE AND IGNORES THE IMPORTANCE TO INSURERS OF ASSESSING AND CONTROLLING THE RISKS THEY ASSUME

This case undeniably presents a substantial question concerning the scope of the "business of [health] insurance" within the meaning of the McCarran Act. It does not, however, entail adoption of a new standard for determining the extent of that business, for *National Securities* has already established the controlling criteria for construing the Act consistent with the intent of its authors. The government's suggestion that new, multiple standards should be substituted for the *National Securities* analysis is not only confusing, but would not effectuate the Congressional purpose and would be unworkable in practice.

The government places special emphasis on a supposed distinction between "risk *underwriting*" or "risk spreading," [12] on the one hand, and "risk *reduction*," on the

[12] At the outset, we note that the government's uses of the terms "underwriting" and "risk spreading" are technically inaccurate. Properly defined, underwriting is the process of selecting risks "in order to determine which of those within a given class offers a probability of loss below that for the average of the class." R. Holtom, *Underwriting Principles and Practices* 123 (1973). Put differently, underwriting is the process of choosing the best customers

other. (U.S. Br. at 17 (emphasis in original)) That test, however, suffers from a fundamentally erroneous view of the insurance business. The government's novel theory is that an insurer's sole function is to assume indeterminate risk without the ability to assess or manage that risk, *i.e.*, to determine the manner in which the policyholder is guaranteed against loss, to contractually limit the risk assumed or to take steps to make the risk more predictable.

The fundamental purpose of all forms of insurance is to substitute "a small, definite cost (the premium) for a large but uncertain loss." [13] The process of determining the amount of premium to cover probable losses is known as the risk assessment process. Because the greater the degree of uncertainty about the magnitude of the risks assumed, the greater the probability that the insurer will not correctly assess its exposure and thus fail to cover actual losses with premium revenues, the risk assessment process necessitates efforts to reduce risks and to make them more readily predictable. In adopting the McCarran Act, Congress recognized the importance of measures to reduce or predict risks: "The most accurate determination of risks, premium rate, and forms of policy is desirable . . . in preserving the solvency of insuring companies, for there can be no true insurance unless rates are adequate." H.R. Rep. No. 873, 78th Cong., 1st Sess. at 9 (1943).

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among those within a given risk classification, all of whom must be charged the same rate. The government incorrectly uses the term to mean the basic function of the contract of insurance, that is, the insurer's assumption of risk. The term "risk spreading" (used by the government interchangeably with "risk underwriting") is not commonly used in the industry.

[13] R. Mehr and E. Cammack, *Principles of Insurance* 32 (5th ed., 1972). *See also* SEC v. Variable Annuity Life Insurance Co., *supra*, 359 U.S. at 71.

The reimbursement formula incorporated in the Pharmacy Agreement is a means of both limiting the magnitude of the risks assumed and improving the insurer's ability to predict future losses.[14] Since before the McCarran Act, it has been recognized that service benefit plans could succeed only if they could predict with reasonable accuracy the total costs of the health care services to be provided. I. S. Falk, *The Costs of Medical Care* 454, 475 (1933). Contracts with providers were essential to meeting that objective. *Id.* at 466.

The provider agreement's specification of a formula for reimbursement for health care services improves the predictability of the costs of health care services and affords the insurer some control over such costs in order to calculate and minimize premium rates. Without such a formula, fully paid service benefits could be provided only if the insurer were to follow the Fifth Circuit's suggestion and pay the provider "whatever" he charged. Such a development would result in a continuous, substantial and unpredictable increase in premium rates which would make service benefits programs almost impossible to administer and financially available to few, if any. H. E. Klarman, *The Economics of Hospital Service*, 29 Harv. Bus. Rev. 71, 79-80 (1951).

The flaws in the government's "risk spreading" standard stem from its transformation of the risk-assuming function from a necessary part of the insurance business to its entirety. The government draws its standard from *Securities and Exchange Commission* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65 (1959). The question before the Court in that case was whether a contract for

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[14] As a risk reduction device, the Pharmacy Agreement is similar to other mechanisms which are undeniably part of the "business of insurance" even though they do not constitute what the government terms "risk spreading." For example, insurers make frequent use of deductibles, exclusions from coverage and ceilings on total dollar liability.

payment of annuities was actually an insurance contract; the Court determined that it was not, since the issuer had not agreed to pay fixed benefits to the annuitant and had not assumed any risk. *Variable Annuity* thus held only that no true contract of insurance existed. It did not attempt to articulate any comprehensive definition of the "business of insurance" and certainly was not intended to limit that business to the naked assumption of risk.

The limited reach of *Variable Annuity* is further shown by the legislative history of the McCarran Act. While the assumption of risk is undoubtedly the *raison d'etre* of the insurance business, if Congress had intended to confine the reach of the exemption to that function, it had ample opportunity to do so explicitly. The Congressional intent is confirmed by rejection of early versions of the McCarran Act which would have limited the exemption to specified activities including, *inter alia*, such "risk spreading" devices as risk-pooling and reinsurance. *See* discussion *supra*, at 16.

Securities and Exchange Commission v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969), interpreted the legislative purpose as to include within the scope of the McCarran Act all activities centrally connected to the insurer-policyholder relationship. While *National Securities* did not undertake an exhaustive listing of all activities within the business of insurance, it did indicate that much more than a skeletal agreement to assume risks was included. Specifically, the type of policy issued, its reliability, interpretation, and enforcement, as well as other activities which relate closely to insurer reliability and solvency, such as the setting of rates, the selling and advertising of policies and the licensing of companies and their agents, were described as parts of that business. 393 U.S. at 460. In applying the broad definition of the insurance business adopted by Congress and fleshed out

in *National Securities*, this Court and the lower courts have determined that a variety of practices other than so-called "risk spreading" are the business of insurance.[15]

In sum, both the legislative history and the plain meaning of the language of the statute, as construed by this Court, the lower courts and the states, demonstrate that the "business of insurance" is not limited solely to "risk spreading."

V. RESTRICTION OF THE "BUSINESS OF INSURANCE" TO HORIZONTAL AGREEMENTS AMONG INSURERS OR ACTIVITIES HAVING NO IMPACT ON OTHER MARKETS WOULD SUBVERT THE PURPOSES OF THE McCARRAN ACT

The government proposes a dichotomy between horizontal agreements, which are recognized to be exempt, and vertical agreements, which are said to be *per se* non-exempt. (U.S. Br. 31-32) The government's arguments appear to be: (1) that Congress did not intend to immunize vertical agreements; (2) that such vertical agreements do not sufficiently concern the relationship between insurers and insureds; and (3) that such agreements have their primary impact in a non-insurance market. None of these arguments finds any basis in the legislative his-

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[15] These include, for example: the selling and advertising of policies, FTC v. National Casualty Co., 357 U.S. 560 (1958); the standardization of policy clauses, American Family Life Assurance Co. v. Aetna Life Insurance Co., 368 F. Supp. 859 (N.D. Ga. 1973); the classifying of risks, Meicler v. Aetna Casualty & Surety Co., 506 F.2d 732 (5th Cir. 1975); and the settlement of claims, Proctor v. State Farm Mutual Automobile Insurance Co., 561 F.2d 262 (D.C. Cir. 1977), *pet. for cert. pending*, No. 77-580. Further, the states have universally acknowledged that the "business of insurance" includes more than so-called "risk spreading" by enacting statutes which, *inter alia*, regulate the relationships between insurers and their agents, prohibit unfair or deceptive sales and claims settlement practices and establish standards for preserving insurer solvency.

tory of the Act, in the decisions construing it or in the realities of the insurance business.

In the course of considering the McCarran Act, Congress was presented with the opportunity to limit the exemption to the horizontal agreements referred to by the government, but chose not to do so.[16] *See* discussion *supra* at 16. Moreover, the fact that the insurer-agent relationship is a vertical one was not intended to exclude that relationship from the scope of the Act where the specific activity in question was of substantial importance to the contract of insurance.[17] Indeed, the policyholder-insurer relationship itself is a vertical one, but it would, of course, be incongruous to argue that the McCarran Act did not cover this relationship merely because a buyer and a seller rather than competitors were involved. Neither could Congress have intended for the labels "vertical" and "horizontal" to be the sole determinants of McCarran Act immunity when, in practical terms, agreements such as Blue Shield's arrangements with pharmacies have a much more direct and profound effect on Blue Shield and the policyholder[18] than "horizontal" ar-

[16] The decisions construing the Act have therefore refused to exempt transactions between insurers where the effect on policyholders is minimal. *See, e.g.*, American General Insurance Co. v. FTC, 359 F. Supp. 887 (S.D. Tex. 1973), *aff'd*, 496 F.2d 197 (5th Cir. 1974) (insurance company mergers). Similarly, in *National Securities* it was the negligible impact on the policyholder of an insurance company's sale of securities which was dispositive, not the vertical configuration of the insurer-shareholder relationship.

[17] A principal allegation in the *Southeastern Underwriters* case was that the defendant rate bureau and its members had refused to do business with agents who represented companies which were not members of the combination. Congress reacted to this problem not by excluding vertical practices from the "business of insurance," but by including them within that business and subjecting boycotts to liability under § 3(b) of the Act. The government concurs that agreements between insurers and their agents may be the "business of insurance." (U.S. Br. at 26, n.14)

[18] The effect of the Pharmacy Agreement upon the policyholder is much more direct than the advertising of policies, FTC v. National

rangements which the government admits to be part of the insurance business.[19]

In its discussion of the purported distinction between vertical and horizontal agreements and particularly in its analysis of the labor exemption cases (U.S. at 34-36), the government also appears to argue that the Pharmacy Agreement is outside the scope of the McCarran Act exemption because it has some effect outside the insurance market. The availability of the exemption, however, cannot be dependent on the absence of any effects in non-insurance markets, since activities shielded by the McCarran Act necessarily have an impact in the market relating to the risk insured. To use the *Proctor* case as an example, a horizontal agreement among automobile insurers on the amounts to be paid in satisfaction of claims has an important effect on the market for automobile repairs; yet, the government concedes that such an agreement would nonetheless be exempt. (U.S. Br. at 31-32)

Neither would a "balancing" test between the effects in the insurance market and effects in the secondary market be consistent with Congressional intent. In enacting the McCarran Act, Congress has declared its policy choice as between the coverage of the antitrust laws and the states' interest in regulating the "business of insurance." Congress' express decision in favor of state regulation indicates the exemption is to be available without countervailing weight being given to allegedly anticompetitive effects in related, non-insurance markets as long as the Congressional purpose of protecting the insurer-

Casualty Co., 357 U.S. 560 (1968), or the licensing of agents, *cf.* Robertson v. California, 328 U.S. 440 (1946), both of which are within the "business of insurance."

[19] Among the horizontal agreements identified by the government are reinsurance pools (U.S. Br. at 24) and insurance association membership rules (*id.*).

policyholder relationship is fulfilled by exempting the conduct in question. The government's distorted labor immunity argument would engraft an unintended limitation upon the scope of the McCarran Act exemption, in essence making it "defeasible" merely by alleging anticompetitive effects in non-insurance markets. Had Congress intended such a limitation, certainly it would have stated so expressly. *Cf.* the boycott exception to the exemption contained in § 3(b) of the Act, 15 U.S.C. § 1013(b) (1976).

Even if it were appropriate to balance the alleged anticompetitive effects of the Pharmacy Agreement in non-insurance markets against the interests protected by the McCarran Act in order to determine the availability of the exemption, the Agreement does not have anticompetitive effects in the retail market for prescription drugs. The government devotes a considerable portion of its brief to acknowledging this fact. (U.S. Br. at 10-14) The key to analysis of the competitive effects of the Pharmacy Agreement lies in the contrariety of the interests of Blue Shield (and its subscribers) and the pharmacies. Blue Shield and its policyholders do not desire to stabilize prescription drug costs at artificially *high* levels, but through contractual arrangements to prevent them from increasing as fast as they might. The purpose and effect of the Pharmacy Agreement are thus fully consistent with the consumer protection objectives of the antitrust laws. (*See* U.S. Br. at 12) Conversely, the economic interest of participating pharmacies runs counter to accepting a prohibitively low level of reimbursement. As a result, the reimbursement level in the Pharmacy Agreement is determined in a competitive framework. It must also be emphasized that nothing in the McCarran Act exempts either Blue Shield or the pharmacy petitioners from acts of boycott against either pharmacies or policyholders.

St. Paul Fire & Marine Insurance Co. v. *Barry*, 46 U.S.L.W. 4971 (U.S. June 29, 1973).[20]

VI. SINCE THE PHARMACY AGREEMENT IS PROTECTED, McCARRAN ACT IMMUNITY IS EQUALLY AVAILABLE TO PARTICIPATING PHARMACIES

Respondents, as does the government, argue that Blue Shield's Pharmacy Agreement is not a part of the "business of insurance" because of its impact in the market for prescription drugs. (Resp. Br. at 48) In other respects, however, respondents take a very different approach from the government, arguing (with some inconsistency) that immunity is unavailable: (1) to Pharmacy Agreements only when they have anticompetitive effects (*id.* at 33-34); (2) to all non-insurance companies

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[20] While respondents have raised what they term "boycott" allegations, their claims are far different from those before the Court in *Barry*. The *Barry* plaintiffs had alleged a total refusal to deal, since they claimed they had been wholly unable to purchase insurance from three of the four insurance company defendants. The outcome in *Barry*, therefore, did not rest on allegations that the insurers had refused to deal except at stated prices or stated coverages. Nor did *Barry* involve a claim that the insurers were exerting only economic coercion on prospective policyholders. In contrast, the respondents in this case contend they are being "boycotted" *only* because Blue Shield's policies: (1) contain an economic incentive for subscribers to patronize participating rather than non-participating pharmacies; and (2) offer an incentive for policyholders to utilize participating pharmacies because they are not required first to purchase drugs out-of-pocket and then seek reimbursement from Blue Shield. These purely economic incentives do not amount to a boycott. As recognized in *Barry*, enforcement by non-economic coercion (*e.g.*, total refusals to deal) is necessary; otherwise, the boycott exception would extend to all violations of the Sherman Act, an extension which would totally subsume the McCarran exemption. 46 U.S.L.W. at 4977. The record demonstrates (McDonald Aff., App. 48; Johnson Depo., App. 147a) and the government agrees (U.S. Br. at 11) that Blue Shield offered the opportunity to all licensed pharmacies in Texas to enter into the Pharmacy Agreement.

(*id.* at 113); and (3) to health care providers when it is alleged that they have agreed in horizontal fashion to enter into vertical contracts with the insurer. (*Id.* at 54)

Respondents concede they are not "attacking contracts between insurers and providers in general and are not alleging that all such contracts are outside the business of insurance." (Resp. Br. at 33) Respondents' argument is instead that provider agreements cannot benefit from the McCarran Act whenever a plaintiff alleges that the effect of the agreement is to fix prices. (*Id.*) To contend that the McCarran Act only protects activities that do not arguably come within the scope of the federal antitrust laws, however, would defeat the very purpose of the exemption.

The argument that non-insurers can never partake of the exemption is similarly flawed. The pharmacy petitioners do not claim that if Blue Shield as an insurer is immune, they too are automatically shielded. Rather, they argue that if the Pharmacy Agreement is part of the "business of insurance" then both signatories necessarily must be immune to effectuate the Act's purposes. The government agrees, correctly interpreting analogous cases exempting collective bargaining agreements to mean that if the agreement is exempt, "neither party to the agreement is liable . . . ." (U.S. Br. at 35, n.23) Any other interpretation would eviscerate the Act by limiting immunity to insurers but exposing providers to the penalties of the federal antitrust laws.

Respondents misconstrue the *National Securities* decision, which, while holding that not all activities of insurance *companies* were the "business of insurance", did not even hint that the activities of non-insurance companies could never be part of that business. Instead, emphasizing that the McCarran Act "refers not to the persons or companies who are subject to state regulation, but to laws 'regulating the *business* of insurance' ", 393 U.S. at

459 (emphasis in original), *National Securities* establishes that the scope of the Act includes *all* conduct within the "business of insurance" regardless of the identity of the actors.[21]

The McCarran Act can be contrasted with other express antitrust exemptions conferring immunity on the basis of the identity of the potential recipients, not the nature of their conduct. For example, this Court has recently determined that the Capper-Volstead Act, 7 U.S.C. § 291 (1976), does not extend to packers or processors in an essentially vertical relationship with poultry farmers since the express language of the act is limited to "farmers." *National Broiler Marketing Association* v. *United States*, 98 S. Ct. 2122 (1978). Consequently, the exemption was restricted to cooperative associations *all* of whose members independently qualified for the exemption as farmers. In contrast, the McCarran Act refers to

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[21] Indeed, the Court noted that agents as well as insurers were potentially eligible for the Act's protections. 393 U.S. at 460. In addition to misconstruing *National Securities*, respondents stretch the lower court opinions on which they rely well beyond their actual holdings. The court in Meicler v. Aetna Casualty & Surety Co., 506 F.2d 732 (5th Cir. 1975) focused, not on the fact that every defendant was an insurance company, but rather on the fact that the challenged activities—risk classification and rate-making—were obviously intended to be immunized by McCarran. In Pastor v. Hartford Fire Insurance Co., 1976-1 CCH Trade Cas. ¶ 60,783 (C.D. Cal. 1976), the district court found that the challenged activities of the Los Angeles County Medical Association were not a part of the business of insurance since they included an alleged conspiracy to monopolize the practice of medicine as well as physicians' liability insurance and, in any event, were not regulated by the State of California. *Id.* at 68,398. Lastly, Center Insurance Agency v. Byers, 1976-1 CCH Trade Cas. ¶ 60,940 (N.D. Ill. 1976), dealt with an alleged conspiracy to pirate trade secrets and convert proprietary advertising programs for the benefit of the insurance companies and not for the benefit of the insureds. Although there is a reference in *dictum* to non-insurance companies being outside the Act's immunity, the district court squarely held that the challenged activities of *all* the defendants "did not involve the 'business of insurance' and therefore are not exempt . . . ." *Id.* at 69,125 (emphasis added).

the "business of insurance" and "every person engaged therein," rather than to "insurance companies," indicating a conduct-oriented test. Congress has thus expressed no similar intent that the exemption be available only when an insurer deals with another insurer.[22]

The McCarran Act would also become a hollow immunity if antitrust plaintiffs could defeat the exemption merely by alleging, as respondents assert they have done (Resp. Br. at 119), that participating pharmacies entered into Pharmacy Agreements on a joint rather than unilateral basis. At the outset, it is important to realize the limited nature of respondents' "horizontal conspiracy" theory. As the government carefully notes, the complaint does not allege facts sufficient to "establish that the participating pharmacies conspired among themselves to obtain a price for distribution higher than they otherwise could obtain." (U.S. Br. at 14, n.6) Neither do respondents sufficiently allege that the Pharmacy Agreement is the means by which participating pharmacies engage in predatory pricing, since the complaint does not assert that the "pharmacy agreements entail sales at less than marginal costs . . ., and the complaint thus does not set out an essential element of predatory pricing." (*Id.*) Thus,

[22] The authorities cited by respondents to the contrary do not involve antitrust exemptions for specified types of conduct. Timken Roller Bearing Co. v. United States, 341 U.S. 593 (1951), did not even involve—as respondents concede (Resp. Br. at 118)—a question of exemption but rather the issue whether inability to obtain jurisdiction over foreign co-conspirators precluded jurisdiction as to a United States corporation. Sloan Shipyards Corp. v. United States Shipping Board Emergency Fleet Corp., 258 U.S. 549 (1939), involved the application of sovereign immunity to a corporation acting as agent of the United States. Unlike the McCarran exemption, sovereign immunity is based upon the identity of the actor in terms of whether or not it assumes the characteristics of a governmental entity. Finally, the only McCarran Act case cited by respondents that is remotely relevant, Pastor v. Hartford Fire Insurance Co., *supra*, expressly left open the question of whether one alleged participant to an antitrust conspiracy may be sued if its co-conspirator is statutorily immune. 1976-1 CCH Trade Cas. ¶ 60,783 at 68,398 (C.D. Cal 1976).

respondents' allegation is reduced to a claim that the pharmacy petitioners agreed only to accept the Agreement offered by Blue Shield, an Agreement which is by itself part of the insurance business. Even as to this allegation, the record evidence is undisputed that there was no collusion between the pharmacy petitioners.[23]

Because respondents do not allege that the pharmacy petitioners' "combination" agreed on anything beyond the express terms of the Pharmacy Agreement, any injury purportedly suffered by respondents would be proximately caused by that Agreement. But Blue Shield's service benefit agreements with pharmacies are exempt as part of the "business of insurance" regulated by Texas. Respondents thus do not allege in this case any injury arising "by reason of anything forbidden in the antitrust laws . . . ." Clayton Act, § 4, 15 U.S.C. § 15 (1976).

VII. ALTHOUGH THE QUESTION OF STATE REGULATION IS NOT BEFORE THE COURT, TEXAS HAS REGULATED THE PHARMACY AGREEMENT THROUGH ITS POLICY APPROVAL AND UNFAIR TRADE PRACTICES LEGISLATION

The question whether Texas has regulated Blue Shield's Pharmacy Agreement was expressly left undecided by the court of appeals (App. 123a), was not presented in the petition for certiorari or opposition and is not therefore before the Court. Respondents' argument (Resp. Br. at 20) that the State Board of Insurance has no regulatory authority over the Agreement or participating pharmacies, however, cannot be left unchallenged.[24]

[23] The evidence before the district court, uncontested by affidavit or other evidence from respondents, demonstrates that there was no conspiracy, horizontal or otherwise. (App. 45a, 95a, 98a; *see* Rule 56(e), Fed. R. Civ. P.)

[24] The government addresses the state regulation issue only briefly (U.S. Br. at 29, n.18). Petitioners do not argue, as the government implies, that regulation by Texas is determinative of whether the

Petitioners have never disputed that Texas insurance officials have no regulatory jurisdiction over pharmacies *qua* pharmacies. However, it is abundantly clear that the State Board had the power to regulate Blue Shield's prescription drug plan, by which it necessarily regulated the Pharmacy Agreement. Specifically, by approving or disapproving the issuance of the prescription drug policy, the State Board had the power effectively to prevent or authorize Blue Shield to enter into agreements with participating pharmacies. The State Board also had the power to determine the provisions of the Pharmacy Agreement through its approval or disapproval of the policy provisions upon which the Agreement was based.

Texas first exercised these approval powers and also applied its unfair trade practices statute, the same statute found to be sufficient state regulation in *Federal Trade Commission* v. *National Casualty Co.*, 357 U.S. 560 (1958), to disapprove Blue Shield's policy and Pharmacy Agreement on the stated ground that there was a "differentiation in benefits as between 'participating provider' dispensed drugs and 'non-participating provider' dispensed drugs." [25] (App. 365-366a) The state's subsequent order authorizing issuance of the policy was also directed to the tripartite nature of the prescription drug plan, which was described as utilizing "drug service contracts, . . . the

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regulated conduct is the "business of insurance" or that Texas could by statute bring practices outside the "business of insurance" within the reach of the McCarran Act. Petitioners do contend that the views of Texas authorities should be considered. The government, in fact, elsewhere admits that the views of state insurance commissioners "are particularly significant because the [McCarran] Act evolved from a draft bill the [National] Association [of Insurance Commissioners] submitted to Congress." (U.S. Br. at 24)

[25] A second and independent ground for initially disapproving the service benefit arrangement was that it violated the Texas antitrust laws, which are specifically made applicable to the "business of insurance." (App. 365a-366a; *see also* Addendum to Brief for Petitioners at Add. 14a-17a)

insurer having entered into participating agreements with dispensing pharmacies to supply the prescribed drugs to its policyholders." [26] (App. 370a-371a) Finally, the state approved in 1974 a virtually identical prescription drug policy. (App. 374-386a) The state's orders are uncontrovertible evidence that Texas considered the very practices now in issue to be part of the insurance business subject to its insurance code and that the state undertook to regulate those practices.[27]

The specific manner in which Texas has chosen to regulate Blue Shield's policies and Pharmacy Agreements—prior approval of policies and prohibition of unfair practices—is immaterial, for the basic purpose of the McCar-

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[26] The State Board's decision to rescind its disapproval and exempt Blue Shield from the policy approval requirement of the Texas Code was made so as not to put Blue Shield, a regulated domestic insurer, at a competitive disadvantage with unregulated, out-of-state insurers offering similar policies. (App. 370a-373a) Blue Shield's insurance plan remained subject to all regulatory statutes, including the unfair practices law. (*See* Brief for Petitioners at 7, n.8) The Texas Insurance Commissioner also referred the policy and the Agreement to the State Attorney General for appropriate action under the state's antitrust laws. (App. 367a-368a; 372a-373a) The policy filed in 1974 was approved rather than exempted. (App. 385a-386a)

[27] In a number of instances, respondents misrepresent the record as it relates to state regulation. For example, respondents claim that Steve G. McDonald, counsel for Blue Shield, testified that the Pharmacy Agreement need not be filed with the State Board for its approval. (Resp. Br. at 18) Portions of Mr. McDonald's deposition testimony not included in the Appendix and not quoted by respondents demonstrate that he was not referring to the Pharmacy Agreement here in issue, but to a Participating Plan Agreement implementing, for employees of Mack Trucks, Inc. living in Texas, a different policy issued and approved in another state. (McDonald Depo. at 20)

While respondents' assertions of a lack of state regulation are baseless, at most they raise factual questions the resolution of which would be proper only at the trial court level since the state regulation issue was decided in favor of petitioners on motion for summary judgment.

ran Act was to permit the states freedom to choose the desired form of regulation. *Prudential Insurance Co.* v. *Benjamin*, 328 U.S. 408 (1946).

VIII. CONCLUSION

For the foregoing reasons, the judgment of the Court of Appeals for the Fifth Circuit should be reversed.

Respectfully submitted,

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FOR ARGUMENT

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In the Supreme Court of the United States

OCTOBER TERM, 1978

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, ET AL., PETITIONERS

v.

ROYAL DRUG COMPANY, INC., ETC., ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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In the Supreme Court of the United States

OCTOBER TERM, 1978

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, ET AL., PETITIONERS

v.

ROYAL DRUG COMPANY, INC., ETC., ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

INTEREST OF THE UNITED STATES

The issues in this case pertain to the scope of the exemption from the antitrust laws afforded to the business of insurance under the McCarran-Ferguson Act, 59 Stat. 33, as amended, 15 U.S.C. 1011-1015. The United States has the primary responsibility for

enforcing the antitrust laws. It therefore has a general concern that statutes creating exemptions from those laws not be interpreted more broadly than necessary to carry out the reasons for those exemptions. The extent to which the antitrust laws apply to the insurance industry is a matter of particular importance to the United States, because the scope of the exemption will affect prosecutorial decisions concerning anticompetitive conduct by insurance companies.

QUESTION PRESENTED

Whether an agreement between an insurance company and a pharmacist, designating the amount the insurance company will pay to the pharmacist for providing prescription drugs for which the insurance company must pay, is part of the "business of insurance" within the meaning of the McCarran-Ferguson Act.

STATUTES INVOLVED

Section 1 of the Sherman Act, 26 Stat. 209, as amended, 15 U.S.C. 1, provides in part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.

The McCarran-Ferguson Act, 59 Stat. 33, as amended, 15 U.S.C. 1011-1015, provides in pertinent part:

> [Section 1] Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.
>
> [Section 2] (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the * * * Sherman Act, and the * * * Clayton Act, and * * * the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.
>
> * * * * *
>
> [Section 3(b)] Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

STATEMENT

Petitioner Blue Shield offers an insurance policy (App. 51a-58a) that covers the risk that a policyholder will need to obtain prescription drugs. The

policy gives the insured person an option in obtaining such drugs. If an insured buys drugs from a "participating" pharmacy, the insured pays the pharmacy only $2.00 (App. 55a). The $2.00 is the total cost to the insured. If the insured buys drugs from a "nonparticipating" pharmacy, he pays the pharmacy the full price charged by the pharmacy and may obtain reimbursement from Blue Shield for 75 percent of the "result of the usual and customary charges for such covered drugs as determined by the Insurer, reduced by [$2.00]" (App. 56a).

Blue Shield offered to enter into a Pharmacy Agreement (App. 59a-61a) with each licensed pharmacy in Texas. Each pharmacy entering into the agreement becomes a "participating" pharmacy. Under the Pharmacy Agreement, the pharmacy agrees to furnish drugs to Blue Shield's insureds for $2.00, and Blue Shield agrees to reimburse the pharmacy for the pharmacy's cost of acquiring the drug.[1]

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[1] The agreement requires Blue Shield to pay the acquisition cost, plus a $2.00 "professional dispensing fee," less the amount paid by the insured. The latter two items offset.

The following example may illustrate the operation of the insurance policy and the Pharmacy Agreement. Suppose the usual and customary retail price for a quantity of Drug X charged both by "participating" Pharmacy A and "non-participating" Pharmacy B is $10.00, and the wholesale price (or acquisition cost) to both is $8.00. If an insured buys Drug X from Pharmacy A, the insured pays $2.00. Pharmacy A receives $2.00 from the insured and $8.00 from Blue Shield, or $10.00 total. If an insured buys Drug X from Pharmacy B, the insured pays Pharmacy B $10.00, and receives $6.00 (75 percent of the difference between the retail price and $2.00) from Blue Shield. While Pharmacy B receives the same as Pharmacy A, the insured must pay $4.00 for the drug and also must take steps to obtain reimbursement.

If the pharmacy's acquisition cost for the drug is $5.00 rather than $8.00, the situations of Pharmacy B and the insured are unchanged. But now Pharmacy A will receive only $5.00 from Blue Shield, for a total of $7.00.

In 1969 Blue Shield filed its proposed prescription drug policy with the Texas State Board of Insurance for approval, as required by Texas law, and annexed to the filed policy the proposed Pharmacy Agreement (App. 352a-353a). After initial disapproval, the Board approved issuance of the policy in September 1969 (App. 370a-371a). The parties disagree about whether that action constituted a review and approval of the annexed Pharmacy Agreement (see Pet. Br. 2, 33-35; Resp. Br. in Opp. 11, 29-30).

In 1975 respondents, who operate non-participating pharmacies in Texas,[2] filed a complaint (App. 2a-11a) against petitioners (Blue Shield and three participating pharmacies), alleging that petitioners had violated Section 1 of the Sherman Act, 15 U.S.C. 1. The complaint charged that the Pharmacy Agreement is an agreement among petitioners to fix the price of drugs, to carry out a group boycott (by the insureds) of non-participating pharmacies, and to allocate territories and impose territorial restrictions (App. 8a-9a).

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[2] The record indicates that nine of the respondents also operate participating pharmacies in Texas (App. 14a, 19a, 31a, 50a).

The district court dismissed the complaint (App. 100a-116a), holding (among other things) that the challenged agreements are exempted from the federal antitrust laws by Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), because the agreements are part of the "business of insurance", are regulated by the State of Texas, and are not boycotts (*id.* at 108a-112a).

The court of appeals reversed (App. 117a-139a). It held that the Pharmacy Agreement is not part of the "business of insurance" because it "goes beyond Blue Shield's obligation as an insurer and places the firm in the business of providing products and services" (App. 129a). Although the Pharmacy Agreement is "somewhat related to the business of insurance * * * [t]he relationship * * * is so attenuated that it must be subject to the antitrust laws" (App. 132a).[3]

SUMMARY OF ARGUMENT

A. There is no issue before this Court concerning the lawfulness of petitioners' agreements or practices under the antitrust laws. Although petitioners and most of the *amici* supporting them argue that insurance plans and provider agreements such as theirs greatly benefit the consumer, those arguments are

[3] Having found that the Pharmacy Agreements are not part of the business of insurance, the court did not reach the other questions decided by the district court. It observed, however, that "there is no * * * indication that the activities complained of are considered the business of insurance by the State" (App. 135a).

irrelevant because there has been no determination that petitioners' plans and practices violate the antitrust laws. As a general matter, moreover, antitrust principles would not preclude the offering of prepaid health plans that use insurer-provider agreements.

Whatever the likelihood of respondents' ultimate success on the merits, however, respondents' complaint formally alleges antitrust violations, and those allegations must be assumed to be true for purposes of ruling on petitioners' motion to dismiss. The issue in the case is whether, on that assumption, the challenged agreements and practices of petitioners are part of the "business of insurance" that Section 2(b) of the McCarran-Ferguson Act exempts from the antitrust laws. Because provider agreements of the kind challenged here could be the vehicle for agreements and practices that violate the antitrust laws, that issue is important for antitrust policy and enforcement.

B. Several considerations support the court of appeals' conclusion that the provider agreements in this case are not part of the "business of insurance" within the meaning of Section 2(b).

1. The analysis of the issue must start from the premise, stated many times by this Court, that exemptions from the antitrust laws must be narrowly construed. See, *e.g.*, *Abbott Laboratories* v. *Portland Retail Druggists Association, Inc.*, 425 U.S. 1, 11-12.

2. The ordinary understanding of the "business of insurance" is the underwriting of risk and the

relationship between the insurer and the persons whose risks are insured. *Securities and Exchange Commission* v. *Variable Annuity Co.*, 359 U.S. 65. Blue Shield's agreements with various pharmacies are not the underwriting of risk; they are merely contracts for the purchase of goods and services at a specified price. The fact that they may be related to Blue Shield's insurance policies does not clothe them with the same status. Everything an insurance company does to make money or to contain or reduce its costs can be said to relate to its insurance, but neither the common understanding of the "business of insurance" nor the legislative intent would include every such activity within the scope of that term.

3. The legislative history and this Court's opinion in *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453, demonstrate that the "business of insurance" was understood by Congress to involve the underwriting of risk and the relationships and transactions between insurance companies and their policyholders. Nothing in that history suggests that Congress intended to exempt agreements or transactions between insurance companies and entities outside the insurance industry. Petitioner's arguments that the Pharmacy Agreements should be regarded as part of the business of insurance because they affect Blue Shield's costs (and therefore the amount of premiums charged) and enhance its status as a reliable insurer are beside the point. If *effect* on insurance were the touchstone, the exemption would

apply to "insurers." It is not written so broadly, however. The "business of insurance" is less than the entire "business of insurers."

An agreement between an insurance company and a non-insurance entity may or may not violate the antitrust laws, depending on its purpose or effect, but it is not exempt from such laws as part of the "business of insurance." If the purpose or effect of such an agreement is to restrain competition in markets other than the insurance market, nothing in the McCarran-Ferguson Act or its legislative history suggests that Congress intended to immunize it from the antitrust laws.

4. These arguments are supported by this Court's decisions concerning the analogous antitrust exemption for labor agreements. It is well established that labor agreements about wages and other conditions of employment are, as a general matter, exempt from the antitrust laws. But where the evidence shows that such an agreement is a device designed to restrain competition among employers or to affect markets other than the labor markets, it has no antitrust immunity. See, *e.g.*, *United Mine Workers* v. *Pennington*, 381 U.S. 657. The same principles support the conclusion that an agreement between an insurance company and a firm selling goods or services is not exempt from the antitrust laws.

ARGUMENT

AGREEMENTS BETWEEN INSURERS AND PROVIDERS OF SERVICES ARE NOT PART OF THE "BUSINESS OF INSURANCE"

A. The Court Need Not Decide Whether The Agreements Violate The Antitrust Laws

This case, in its present posture, does not require the Court to decide whether the Pharmacy Agreements violate the antitrust laws. The only question is one of immunity from the antitrust laws, and if this Court should hold that there is no immunity the lower courts would then be required to consider whether the practices are lawful. It should go without saying that agreements and practices can be non-immune and still be perfectly lawful.

Petitioners and *amici* supporting them devote most of their briefs to arguing that provider agreements such as the Pharmacy Agreements are integral to prepaid health insurance programs and that they are reasonable and in the interest of the consumer. Respondents argue that the Pharmacy Agreements are price-fixing and violate the antitrust laws in other ways. These arguments, however important they may be in determining questions of substantive antitrust law, are irrelevant to the immunity issue.

As a general matter, however, antitrust principles would not preclude the offering of prepaid health in-

surance programs that use insurer-provider agreements. For example, the pleadings in this case indicate that the Pharmacy Agreements are bilateral contracts for the purchase of goods and services by Blue Shield. Blue Shield has offered to purchase drugs and pharmacy services from any pharmacy that will accept acquisition cost plus $2.00. Unless respondents could establish that some conspiracy among pharmacies is at work the Pharmacy Agreements would not amount to "price fixing." Transactions at a set price, through a series of voluntary bilateral contracts, are not price fixing even though large numbers of sellers of services may be involved. *Theatre Enterprises, Inc.* v. *Paramount Film Distributing Corp.*, 346 U.S. 537; *Dahl, Inc.* v. *Roy Cooper Co.*, 448 F.2d 17 (C.A. 9). Cf. *Tampa Electric Co.* v. *Nashville Coal Co.*, 365 U.S. 320.

For all that appears on the face of the complaint, Blue Shield has acted as an agent of the policyholders to secure drug distribution services at the lowest possible cost. Blue Shield has offered to deal directly with any pharmacy willing to accept a low price for its services. Any pharmacy that can distribute drugs for $2.00 or less per prescription could accept Blue Shield's offer. This process serves to help the policyholders find low-overhead pharmacies with which to deal. Moreover, it provides pharmacies with incentives to reduce their distribution costs in order to be

able to take advantage of Blue Shield's offer and still make a profit.

Respondents' principal complaint seems to be that the series of Pharmacy Agreements—which make it advantageous for policyholders to patronize pharmacies that are willing to take only $2.00 for distribution services—prevents them from obtaining as much money as they need or desire (App. 7a-8a; Br. in opp. 5-10). That kind of complaint does not state an antitrust violation. Nothing in the antitrust laws requires drug purchasers (or Blue Shield acting as their purchasing agent) to offer the greater compensation necessary to satisfy less efficient pharmacies or suppliers interested in providing expensive but unwanted services at the point of sale. To the contrary, antitrust policy seeks to preserve to consumers the opportunity to obtain a better deal. Its goal is consumer welfare, not competitor welfare. See *National Society of Professional Engineers* v. *United States*, No. 76-1767, decided April 25, 1978; *Continental T.V., Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36; *Brunswick Corp.* v. *Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488; *Brown Shoe Co.* v. *United States*, 370 U.S. 294, 320.[4] Indeed, in 1968 the Department of Justice issued a business review letter indicating that agreements between individual insurers and individual providers, to carry out a prepaid insurance plan, do not violate the antitrust laws

[4] See also 1 Areeda and Turner, *Antitrust Law* ¶¶ 103-113 (1978); 3 *id.* at ¶ 732.

(Department of Justice Clearance letter, January 15, 1968, reproduced at App. E of Amicus Br. of the Blue Shield Association).[5]

Nevertheless, the complaint in this case at least formally sets out the elements of a violation of the antitrust laws, and in passing on the immunity arguments it is necessary to assume that the Pharmacy Agreements are combinations or conspiracies in restraint of trade.[6] The dispositive issue is whether, on

[5] Several portions of the court of appeals' opinion appear to characterize petitioners' activities as coercive or as "price fixing" (*e.g.*, App. 127a, 137a). It may be that the court was simply assuming, as it was required to do, that respondents ultimately could make out a violation of the antitrust laws. To the extent the court of appeals was indicating that the conduct described in the complaint is a *per se* violation of the Sherman Act, we cannot agree with that view for the reasons stated in the text.

[6] The most troublesome opportunity for a restraint of trade would exist if the providers of goods and services also controlled the insurance companies. If, for example, pharmacies controlled Blue Shield, and if Blue Shield also possessed substantial power in the insurance market, the providers could use the insurance business to make or carry out their agreement in restraint of trade. They might agree to increase prices and carry out the agreement through their control of the insurers. Although such a development would be of considerable concern to the United States and to the Federal Trade Commission, the complaint in the present case does not allege that the pharmacies control Blue Shield and can require it to act in the interest of pharmacies rather than policyholders.

Provider agreements might violate the antitrust laws even in the absence of an allegation of "provider control." It is possible,

that assumption, the Pharmacy Agreements are exempt from antitrust scrutiny as part of the "business of insurance" within the meaning of Section 2(b) of the McCarran-Ferguson Act. We submit that they are not.

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for example, that evidence might establish that the participating pharmacies conspired among themselves to obtain a price for distribution higher than they otherwise could obtain. In that event, however, Blue Shield and the insureds would be the victims of the conspiracy, and they would join it only if faced with a united group of providers. In other words, an effective provider conspiracy could not succeed unless it could obtain the support of most pharmacists, because otherwise non-members of the cartel would offer competitive prices and attract the business. The complaint here does not allege facts sufficient to show an antitrust violation under this theory.

There would be genuine antitrust concern, too, if it could be established that the participating pharmacies are using the Pharmacy Agreements to engage in predatory pricing. Again, however, Blue Shield would not participate in that conspiracy, which would work to the long-run detriment of the insureds, unless confronted with an agreement involving a substantial proportion of the pharmacies. Moreover, there has been no allegation that the Pharmacy Agreements entail sales at less than marginal cost (see 3 Areeda and Turner, *supra*, at ¶¶ 710-722), and the complaint thus does not set out an essential element of predatory pricing. It also would be significant to a predatory pricing case whether new pharmacies could enter the market to replace pharmacies that had been driven out. If there were prompt entry, the predators could not capture for long the increased market share that is necessary to make predation profitable. The complaint does not allege that barriers to entry would prevent renewed competition from overcoming the hoped-for effects of predation.

B. The Pharmacy Agreements Are Contracts For The Purchase And Sale Of Distribution Services

The McCarran-Ferguson Act does not define the "business of insurance," and the legislative history does not provide a definitive explanation of the phrase. *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453, 458. Several considerations, however, support the court of appeals' conclusion that the Pharmacy Agreements are not part of the "business of insurance."

1. *Antitrust exemptions must be narrowly construed*

Analysis of the question must begin with the general principle that exemptions from the antitrust laws are to be narrowly construed and limited to the scope clearly defined by Congress. *Abbott Laboratories* v. *Portland Retail Druggists Association, Inc.*, 425 U.S. 1, 11-12; *Federal Maritime Commission* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733. Cf. *National Broiler Marketing Association* v. *United States*, No. 77-117, decided June 12, 1978; *Maryland and Virginia Milk Producers Association, Inc.* v. *United States*, 362 U.S. 458, 464-467. It would be inappropriate to conclude that the competitive restraints alleged to exist here are exempt from the antitrust laws unless the purpose of the McCarran-Ferguson Act or the clear legislative history requires that result.

2. *The provider agreements do not pool or spread risk*

Because there is no statutory definition of the "business of insurance," it is appropriate to consider first the common and ordinary meaning of the term.

See *Ernst & Ernst* v. *Hochfelder*, 425 U.S. 185, 199 and n. 19. And, as commonly understood, the business of insurance does not include the kind of provider agreements involved in this case.

In common parlance, the "business of insurance" is the underwriting of risk and the relationships and transactions between the insurance company and the persons whose risks are insured. This Court so held in *Securities and Exchange Commission* v. *Variable Annuity Co.*, 359 U.S. 65. In that case a company had issued annuities, the benefits of which depended on the success or failure of a portfolio of stocks in which the premiums were invested. Because the risk thus fell on the annuitant and not the company, the Court held that the annuities were not part of the "business of insurance" that the McCarran-Ferguson Act exempted from Commission regulation: "There is no true underwriting of risks, the one earmark of insurance as it has commonly been conceived of in popular understanding and usage." 359 U.S. at 73 (footnote omitted).

The Pharmacy Agreements are not an underwriting of risk. They are merely contracts for the purchase of drugs and distribution of services for Blue Shield's customers. They are not part of the business of insurance "as it has commonly been conceived of in popular understanding and usage." [7]

[7] In a sense, of course, every contract for the sale of goods or services in the future at a specified price protects the parties against the risk of future fluctuations in the market price, but that is clearly not the kind of underwriting of risk that is commonly understood to constitute, or is in any way peculiar to, the "business of insurance."

There is an important distinction between risk *underwriting* and risk *reduction*. The Pharmacy Agreements reasonably could be viewed as a method of reducing Blue Shield's risk. By agreeing with pharmacies on the price it will pay for drugs, Blue Shield has reduced the total amount it must pay to fulfill its risk-related obligations to its policyholders. But this device does not spread risk more widely or reduce the role of chance events (illnesses, *e.g.*) in Blue Shield's business. The Pharmacy Agreements may eliminate some risk, but they do not underwrite risk.

Many practices that could be undertaken by insurance companies and by other persons could affect the total amount of risk. For example, an automobile manufacturer that invents a more effective bumper could make safer cars, reducing the loss caused by accidents. If the large insurance companies then agreed with the principal automobile manufacturers that the safer bumper would be installed on every car, whether or not the consumer wanted the new bumper, this would reduce still further the loss caused by accidents. The decreased loss would affect, perhaps significantly, the premiums for automobile insurance. But no one would think that this process of invention, followed by a combination or agreement to sell only cars equipped with the new bumper, was part of the business of insurance. The fact that the agreement involved manufacturers and insurers, rather than manufacturers alone, would not affect its nature. The explanation of this intuitive reaction is that the invention and agreement—no matter how desirable to

society—simply reduces loss and risk. It does not spread risk more widely or more effectively. It is risk reduction rather than risk underwriting.[8] The same principle applies here: the Pharmacy Agreements reduce but do not spread risk, and they are thus not part of the "business of insurance."

The fact that transactions or agreements may have some relationship to a company's insurance business or its insurance policies does not make all of those transactions or agreements part of the business of insurance. Insurance companies engage in many transactions that are more or less related to, or even necessary for, its insurance functions. They contract with printers to obtain insurance policy forms, lease buildings to carry out their business, and lend money to raise the funds necessary to carry out the promises made in their policies. But none of those activities would commonly or reasonably be regarded as the "business of insurance." Moreover, as we now discuss, there is no reason to conclude that Congress intended to exempt from the antitrust laws an insur-

[8] Similarly, an insurance company might conduct medical research designed to find a way to prevent cancer or to cure the common cold. It might make discoveries that would allow large savings in the cost of medical care or obliterate the need to purchase many prescription drugs that are now sold. Such discoveries would have considerable effects on insurance rates and on the terms of policies. But no one would argue that this medical research—or a contract between an insurance company and a laboratory to conduct medical research—is part of the "business of insurance." It is part of the business of medicine, and although it may reduce risk it would not underwrite risk.

ance company's participation in a price-fixing agreement among printers or building owners or other lenders.

3. *The legislative history indicates that ancillary business agreements of insurers are not part of the "business of insurance"*

a. Although the legislative history of the McCarran-Ferguson Act does not provide a definitive explanation of the term "business of insurance," that history, which this Court has reviewed on several occasions, does demonstrate that Congress' concern was with the relationship between the insurer and the insured, and with preserving state regulation of that relationship. Nothing in the legislative history suggests that Congress intended to immunize relationships or transactions between insurance companies and other entities (such as pharmacies) outside the insurance industry, even though such relationships or transactions may be more or less "related" to the insurance function (as they always would be to some degree when one party is an insurance company).

Securities and Exchange Commission v. *National Securities, Inc.*, *supra*, is this Court's most extensive consideration of the legislative history of the Act. The Court held that the Securities and Exchange Commission was not precluded from seeking to dissolve a merger between two insurance companies that had been approved by the state insurance director but that allegedly violated the federal securities laws. The Court concluded that state regulation of insur-

ance company mergers designed to protect stockholders was not regulation of the "business of insurance" within the meaning and intent of the McCarran-Ferguson Act,* and the Court's discussion of the legislative history provides significant guidance for the resolution of the issue in this case.

The Court first noted (393 U.S. at 458) that the McCarran-Ferguson Act was passed in response to *United States* v. *South-Eastern Underwriters Association*, 322 U.S. 533, in which this Court had held that insurance transactions were transactions in interstate commerce and thus subject to the antitrust laws. As a result of fears that *South-Eastern Underwriters* might displace or invalidate traditional state regulation and taxation of the insurance industry, Congress enacted the McCarran-Ferguson Act "to give support to the existing and future state systems for regulating and taxing the business of insurance." *Prudential Insurance Co.* v. *Benjamin*, 328 U.S. 408, 429. See also *St. Paul Fire & Marine Insurance Co.*

* In that case the issue concerned the application of the provision in Section 2(b) that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance * * *." This case concerns the portion of Section 2(b) that relates specifically to the Sherman, Clayton and Federal Trade Commission Acts and provides that those Acts "shall be applicable to the business of insurance to the extent that such business is not regulated by State law." While there are differences between the operation of the two provisions that are not relevant here, the term "business of insurance" has the same scope in both provisions, and the analysis of *National Securities* is therefore pertinent.

v. *Barry*, No. 77-240, decided June 29, 1978, slip op. 6-7.

The Court then stated that (393 U.S. at 459-460; emphasis in original):

> it is relatively clear what problems Congress was dealing with. Under the regime of *Paul* v. *Virginia*, *supra*, States had a free hand in regulating the dealings between insurers and their policyholders. Their negotiations, and the contract which resulted, were not considered commerce and were, therefore, left to state regulation. The *South-Eastern Underwriters* decision threatened the continued supremacy of the States in this area. The McCarran-Ferguson Act was an attempt to turn back the clock, to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation.
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> Given this history, the language of the statute takes on a different coloration. The statute did not purport to make the States supreme in regulating all the activities of insurance *companies*; its language refers not to the persons or companies who are subject to state regulation, but to laws "regulating the *business* of insurance." Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the "business of insurance" does the statute apply. Certainly the fixing of rates is part of this business; that is what *South-Eastern Underwriters* was all about. The selling and advertising of policies, *FTC* v. *National Casualty Co.*, 357 U.S. 560 (1958), and

the licensing of companies and their agents, cf. *Robertson* v. *California*, 328 U.S. 440 (1946), are also within the scope of the statute.

The Court concluded (393 U.S. at 460):

> Congress was concerned with the type of state regulation that centers around the contract of insurance, the transaction which *Paul* v. *Virginia* held was not "commerce." The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the "business of insurance." Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."

The legislative history confirms what the Court stressed in *National Securities*—that Congress' concern was with the relationship between the insurance company and the insured. First, the debates and committee reports on the Act and earlier versions of it consistently reflect the understanding that the underwriting of risk is the "business of insurance"; Congress wanted to preserve the states' traditional regulation of that function. See 90 Cong. Rec. 6544 (1944) (remarks of Rep. Clason); 90 Cong. Rec. 6526 (Rep. Hancock); H.R. Rep. No. 873, 78th Cong.,

1st Sess. 8-9 (1943);[10] S. Rep. No. 1112, 78th Cong., 2d Sess. 6 (1944). Second, Congress rejected several proposed bills that would have more broadly exempted from the antitrust laws "the business of insurance or * * * acts in the conduct of that business * * *."[11]

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[10] For example, the House Judiciary Committee Report on H.R. 3270, a forerunner of the McCarran-Ferguson Act, recognized that insurance is the "distribution of risk according to hazard, experience, and the laws of averages." H.R. Rep. No. 873, 78th Cong., 1st Sess. 8-9 (1943). These factors, the report stated, "are not within the control of insuring companies in the sense that the producer or manufacturer may control cost factors." *Id.* at 9.

These conclusions were echoed in S. Rep. No. 1112, 78th Cong., 2d Sess. 6 (1944), which viewed insurance as a personal promise of indemnity, and thus "something quite different from the ordinary commercial transaction."

[11] In anticipation of the *South-Eastern Underwriters* decision, three identical bills were introduced in the 78th Congress, which would have made the Sherman and Clayton Acts inapplicable to the business of insurance: H.R. 3269, H.R. 3270 and S. 1362, 78th Cong., 1st Sess. (1943). These bills provided that nothing in the Sherman or Clayton Acts "shall be construed to apply to the business of insurance or to acts in the conduct of that business or in any wise to impair the regulation of that business by the several States." None of these bills was enacted. S. Rep. No. 1112, 78th Cong., 2d Sess. (1944); H.R. Rep. No. 873, 78th Cong., 1st Sess. (1943). The bill that became the McCarran-Ferguson Act, S. 340, was introduced early in the 79th Congress and was reported favorably by the Senate Judiciary Committee on January 24, 1945. S. Rep. No. 20, 79th Cong., 1st Sess. (1944). At approximately the same time Rep. Walter introduced a similar measure (H.R. 1973, 79th Cong., 1st Sess. (1945)), which was reported favorably by the House Judiciary Committee on February 8, 1945. The McCarran-Ferguson Act was amended on the floor of the Senate and passed as amended. It was referred to the House Judiciary Committee, which struck the entire substance

Third, the limits on the scope of the "business of insurance" are reflected in the comments of the Association of Insurance Commissioners, whose views (as petitioners agree, Pet. Br. 31 n. 28) are particularly significant because the Act evolved from a draft bill the Association submitted to Congress. See 91 Cong. Rec. 483 (1945) (remarks of Sen. O'Mahoney). The Association's draft bill specifically listed the activities that the Association believed warranted exemption from the antitrust laws, including agreements concerning rates, forms and rules, agents' commissions, reinsurance, and the pooling of statistics. 90 Cong. Rec. A4406 (1944).[12] All of the listed activities concerned agreements within the insurance industry, agreements that related directly to the pooling of risk and the sale of policies. Nothing in the Association's draft or supporting statements indicated an understanding that ancillary purchases of goods and serv-

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of the bill, substituted the language in the Walter bill, and reported S. 340 as amended. H.R. Rep. No. 143, 79th Cong., 1st Sess. (1945). This bill was passed by the House. A Conference Committee added Section 2(b) and reported the bill. H.R. Conf. Rep. No. 213, 79th Cong., 1st Sess. (1945). This bill passed both Houses of Congress and was signed by President Roosevelt on March 9, 1945.

[12] In his statement before the Joint Hearing of the Subcommittees of the Committee on the Judiciary, on S. 1362, H.R. 3269, and H.R. 3270, 78th Cong., 1st Sess. 219 (1943), A. V. Gruhn, then Manager of the American Mutual Alliance of Chicago, expressed the same views concerning what constitutes insurance and why it required special exemption from the antitrust laws. Edward L. Williams, the President of the Insurance Executives Association, expressed identical views. *Id.* at 259, 266.

ices by insurance companies were intended to receive antitrust immunity. See 90 Cong. Rec. A4403-A4408 (1944).

Finally, the views of Mr. Chief Justice Stone, dissenting in *South-Eastern Underwriters*, are pertinent because the McCarran-Ferguson Act was enacted to overrule that case. Mr. Chief Justice Stone stated that although, in his view, the issuance of insurance was not interstate commerce subject to the antitrust laws, use of insurance contracts to restrain commerce in other goods or services would be subject to antitrust enforcement (322 U.S. at 570-571):

> If contracts of insurance are in fact made the instruments of restraint in the marketing of goods and services in or affecting interstate commerce, they are not beyond the reach of the Sherman Act more than contracts for the sale of commodities * * *.

It is not unreasonable to ascribe the same view to the 78th Congress.[13]

In sum, the legislative history of the McCarran-Ferguson Act and this Court's decision in *National Securities* demonstrate that Congress sought to preserve state regulation of the relationships and trans-

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[13] The remarks of Attorney General Biddle, testifying in the Joint Hearing on S. 1362, H.R. 3269, and H.R. 3270 before the Subcommittees of the Committee on the Judiciary, 78th Cong., 1st Sess. 41-42 (1943), cited by petitioners (Br. 22-23), do not indicate that he considered insurer-provider agreements part of the business of insurance. Rather, the Attorney General's remarks merely indicate a belief that prepaid health plans are the business of insurance, a view that is not now in dispute.

actions between insurance companies and their policyholders. Unquestionably, as the Court noted in *National Securities*, certain other activities of insurance companies may be "relate[d] so closely to their status as reliable insurers that they too must be placed in the same class" (393 U.S. at 460).[14] But there is no basis in the legislative history or policies of the Act for concluding that an agreement between an insurance company and a supplier of goods or services other than insurance is part of the "business of insurance" or is something Congress wanted to exempt from the antitrust laws.[15]

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[14] As one court of appeals has said, "[t]he question is ultimately one of line-drawing, based on the facts of the individual case." *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, 561 F. 2d 262, 268 (C.A.D.C.), petition for a writ of certiorari pending, No. 77-580. One example of the "business of insurance" not directly involving insurer-insured relationships, would be agreements and transactions between insurance companies and independent insurance agents relating to sales of insurance by those agents. While such agreements or transactions do not themselves concern the relationship between the insurer and the insured, they are plainly closely related. Such agreements or transactions are readily distinguishable from provider or supplier agreements, since an insurance agent sells insurance, and a provider or supplier sells other goods or services.

[15] What is more, the legislative history indicates that Congress believed that traditional state regulation of the insurer-insured relationship would adequately protect the public, and Section 2(b) accordingly exempts the "business of insurance" from the antitrust laws "to the extent that such business is regulated by State law." On the basis of the expressed congressional intent to defer to state regulation of that business, courts have held that state regulation of the business need not be affirmative or effective to supplant the federal antitrust laws. *Federal Trade Commission* v. *National Casualty Co.*, 357 U.S. 560, 564; *Dexter* v. *Equitable Life Assurance Society*, 527 F.2d 233 (C.A. 2); *Crawford* v. *American Title Insurance Co.*, 518 F.2d 217, 219 (C.A. 5). Accordingly, if the "business of insurance" were construed broadly to include activities on the periphery of that business, there would be a substantial danger that the public would lack any effective protection from deceptive or anticompetitive practices, contrary to Congress' expectations and premise in enacting the McCarran-Ferguson Act. This consideration counsels that, in close cases, doubts be resolved against including particular activities within the "business of insurance" and reinforces the traditional rule that exceptions to the antitrust laws should be narrowly construed (see page 15, *supra*).

b. Petitioners argue that Blue Shield's Pharmacy Agreements are part of the "business of insurance" because they involve the type of insurance policy Blue Shield issues, its reliability, interpretation and enforcement, and Blue Shield's status as a reliable insurer (Pet. Br. 21-31). They maintain that the Pharmacy Agreements enable Blue Shield to fulfill its obligations to its policyholders and to make sure that they receive benefits at the lowest possible price.

These arguments prove too much, for they would encompass almost everything an insurance company does. For example, an insurance company that agrees with other lenders to fix lending rates could, under petitioners' arguments, reasonably claim that the purpose of the agreement was to keep premium charges down and to ensure that the company remained sound

enough to pay insurance obligations.[16] The same purposes and justifications could be advanced for any other anticompetitive conspiracy between an insurance company and a group of suppliers that redounded to the benefit of the insurance company.[17] But, as this Court recognized in *National Securities*, "[i]nsurance

[16] The fact that the insurance policy itself makes reference to "participating pharmacies," and thus implicitly contemplates the subsequent arrangements between the insurer and the pharmacies, does not affect this case. If, for example, an insurance policy made reference to a proposed price-fixing agreement among the insurer and other lenders and asserted that the proposed agreement was for the purpose of enhancing the insurer's ability to pay claims on the policy, there is no reason to assume that the mere reference in the policy would immunize the price-fixing agreement.

[17] We emphasize once more that the issue of the lawfulness of the agreement should not be confused with the issue in this case. Since there may be anticompetitive agreements or practices between an insurance company and entities outside the insurance industry in which the insurance company would have an incentive to engage, the principle that the "business of insurance" exemption should be narrowly construed is important to antitrust policy.

Indeed, petitioners (Br. 39) and several *amici* (UAW and AFL-CIO Br. 15-19; Motor Vehicle Manufacturers Association Br. 18-19) appear to recognize that provider agreements do not necessarily violate the antitrust laws. They argue that the mere possibility of suits, however unmeritorious, will inhibit socially desirable prepayment insurance plans. This Court, however, recently rejected a similar claim for antitrust exemption based on the argument that the mere threat of unmeritorious lawsuits would adversely affect the operations of municipal governments. *City of Lafayette* v. *Louisiana Power & Light Co.*, No. 76-864, decided March 29, 1978.

companies * * * do many things" (393 U.S. at 459), and it was not the intent of the McCarran-Ferguson Act to exempt everything an insurance company does from the antitrust laws.[18] See also pages 17-18, *supra*, which discuss the important difference between the risk underwriting and risk reduction.

c. Most of the federal courts that have dealt with provider agreements similar to petitioners' have concluded that, because such agreements may affect the premiums charged and consequently may affect the

[18] Petitioners also argue (Br. 31-35) that the Pharmacy Agreements are part of the "business of insurance" because, petitioners claim, they are regulated by the Texas State Board of Insurance and because the Texas Attorney General has opined that prescription drug insurance "plans" (which petitioners claims include provider agreements) constitute the "business of insurance." Respondents dispute that Texas exercises any jurisdiction over the Pharmacy Agreements and that the State has authoritatively spoken on the issue (Br. in Opp. 11, 29, 30), and the court of appeals held that "there is no * * * indication that the activities complained of are considered the business of insurance by the State" (App. 135a). While the court of appeals' view seems to us correct, the issue is not significant, because, as petitioners concede (Br. 3[illegible] n. 28), the meaning of the "business of insurance" is a federal question. A state cannot authorize a violation of the federal antitrust laws, or confer an antitrust immunity, simply by encouraging or approving private anticompetitive conduct. *Cantor* v. *Detroit Edison Co.*, 428 U.S. 579; *Schwegmann Bros.* v. *Calvert Distillers Corp.*, 341 U.S. 384.

We do not understand petitioners to claim that the State has dictated the terms of the Pharmacy Agreement in a way that would provide a defense under the doctrine of *Parker* v. *Brown*, 317 U.S. 341. There seems little basis for such a claim, which, in any event, would be a matter to be determined at a trial on the merits.

insurer's reliability, they are part of the "business of insurance." [19] To the extent those decisions rest on the proposition that agreements or practices come within the business of insurance when they can be said to affect premium charges or the financial soundness of the insurance company, we disagree for the reasons we have previously stated.

It may be useful, however, to discuss *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, 561 F. 2d 262 (C.A.D.C.), petition for a writ of certiorari pending, No. 77-580, because that decision illustrates the prevailing rationale of the lower courts. Certain auto body repair shops sued five insurers, claiming that the insurers had violated the Sherman Act (1) by agreeing among themselves to pay their insured's claims for auto repairs on the basis of an agreed formula involving the "prevailing labor rate" and (2) by agreeing with certain repair shops to fix the price of auto repairs. The court concluded that both

[19] See *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, 561 F. 2d 262 (C.A.D.C.), petition for a writ of certiorari pending, No. 77-580; *Doctors, Inc.* v. *Blue Cross of Greater Philadelphia*, 557 F. 2d 1001 (C.A. 3); *Travelers Insurance Co.* v. *Blue Cross of Western Pennsylvania*, 481 F. 2d 80 (C.A. 3); *Frankford Hospital* v. *Blue Cross of Greater Philadelphia*, 417 F. Supp. 1104 (E.D. Pa.), affirmed, 554 F. 2d 1253 (C.A. 3); *Anderson* v. *Medical Service of the District of Columbia*, 1976-1 CCH Trade Cases ¶ 60,884 (E.D. Va.), affirmed, 551 F. 2d 304 (C.A. 4); *Manasen* v. *California Dental Services*, 424 F. Supp. 657 (N.D. Cal.). But cf. *Battle* v. *Liberty National Life Insurance Co.*, 493 F. 2d 39 (C.A. 5), certiorari denied, 419 U.S. 1110; *Hill* v. *National Auto Glass*, 293 F. Supp. 295 (N.D. Cal.).

types of the alleged agreements are part of the "business of insurance," although it confessed "somewhat more difficulty with [the] allegations of vertical arrangements with preferred shops and a group boycott of non-cooperative shops." 561 F. 2d at 267.

We agree with the court's conclusion about the horizontal agreements among the insurance companies. They are wholly intra-insurance industry agreements concerning the extent to which particular claims would be paid. The formula for the payment of insurance claims is an integral part of any contract of insurance, because it determines how much risk is involved, and how much of the risk will be assumed by the insurer. Such agreements among insurers are no different in substance from agreements on the premiums to be charged,[20] and the McCarran-Ferguson Act's chief purpose was to leave such matters exclusively to state regulation. It may be, of course, that the mechanism chosen to enforce the agreement might amount to "boycott, coercion, or intimidation," in which case the antitrust laws would apply (see *St. Paul Fire & Marine Insurance Co.* v. *Barry*, *supra*, slip op. 12-13 and n. 18), but the agreement is still part of the business of insurance.

We do not agree, however, with the court's conclusion that vertical agreements between insurance com-

[20] To take the simplest example, an agreement between two life insurance companies to charge a $10 premium for every $1000 of death benefits is the same thing as an agreement to pay $1000 of death benefits for every $10 of premiums collected from the deceased.

panies and auto repair shops are also part of the business of insurance if they can be said to have a "vital impact on [the insurers' insurance] rates * * *." 561 F. 2d at 270. That principle would exempt almost any kind of anticompetitive practice, if it could be shown that the practice were sufficiently advantageous to the company that it could pass along the advantage to its insureds in the form of lower premiums.

Although any definition of the "business of insurance" requires a certain amount of "line-drawing" (563 F.2d at 268), it is incorrect to draw the line on the basis of the effect that a particular practice may be said to have on premium charges or insurance benefits. See also pages 16-19, *supra*. The appropriate principles, in our view, may be summarized as follows: If two or more insurance companies agree on the premiums to be charged for insurance or on the benefits to be paid for a given insured loss, such agreements are part of the "business of insurance" and are ordinarily immune from antitrust scrutiny (if they are regulated by state law). If individual insurers then enter into contracts with suppliers or providers solely for the purpose of implementing a lawful agreement among the insurers, those contracts are lawful but not immune. They are lawful not because the provider contracts are also part of "the business of insurance" or because they have a "vital impact on [insurance] rates," but simply because they

are lawful under standard antitrust analysis. But if the provider contracts have some other purpose or effect that is unlawful under the antitrust laws (*e.g.*, to fix prices or reduce competition in the provider market, as alleged in this case), then their lack of immunity becomes important, and antitrust scrutiny is appropriate.[21]

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[21] Indeed, we suggest that the opinion in *Proctor* reflects much of our analysis. It seems likely that the court's conclusion on immunity was based more on its view of the antitrust merits of the complaint than on whether an agreement between an insurer and a supplier of goods or services is the business of insurance. Thus the court stated (561 F. 2d at 268 n. 10):

> It is not contended that [the insurers'] effort to give business to some shops, and take away business from other shops, was motivated by reasons independent of the prices charged by those shops. Nor is it alleged that [the insurers] were trying to drive existing body shops out of business in order to facilitate vertical integration by insurance companies into the auto repair industry. We therefore need not decide whether the presence of such factors would have placed the disputed activities outside the business of insurance.

That statement suggests that if the complaint states a meritorious antitrust complaint, or the proof establishes it, the transaction is not in the "business of insurance." We do not agree with a method of analysis that makes immunity turn on the merits of the antitrust complaint (see pages 10-11, *supra*), but the court of appeals' approach may explain much of its immunity discussion that otherwise appears to be at odds with our submission.

4. *The labor immunity cases*

This Court's decisions concerning the somewhat analogous antitrust exemptions provided to labor unions and their collective bargaining activities by Sections 6 and 20 of the Clayton Act, 38 Stat. 731, 738, 15 U.S.C. 17 [22] and 29 U.S.C. 52, and the Norris-LaGuardia Act, 47 Stat. 70, 71, 73, 29 U.S.C. 104, 105, 113, support our position here. It is well established that those statutory exemptions shield labor organizations and employers from antitrust liability with respect to negotiations and agreements between unions and employers (or employer groups) about wages and other conditions of employment. But those exemptions do not apply to agreements between unions and employers that are designed to restrain competition among employers—for example, to fix prices in the employers' market or to drive certain employers out of business—even if such agreements are embodied in collective bargaining agreements and may redound to the benefit of some workers by enabling the employers to pay higher wages. *Connell Construction Co.* v. *Plumbers & Steamfittters*, 421 U.S. 616; *Ramsey* v. *United Mine Workers*, 401 U.S. 302, 313; *United Mine Workers* v. *Pennington*, 381 U.S. 657,

[22] Section 6 of the Clayton Act, 15 U.S.C. 17, provides in pertinent part:

> * * * Nothing contained in the antitrust laws shall be construed to forbid the existence and operation of labor * * * organizations * * * or to forbid or restrain individual members of such organizations from lawfully carrying out the legitimate objects thereof * * *.

664-665; *Allen Bradley Co.* v. *International Brotherhood of Electrical Workers*, 325 U.S. 797, 807.[23] As the Court said in *Pennington, supra*, 381 U.S. at 665-666 (footnote omitted):

> [A] union may make wage agreements with a multi-employer bargaining unit and may in pursuance of its own union interests seek to obtain the same terms from other employers. No case under the antitrust laws could be made out on evidence limited to such union behavior. But we think a union forfeits its exemption from the antitrust laws when it is clearly shown that it had agreed with one set of employers to impose a certain wage scale on other bargaining units. One group of employers may not conspire to eliminate competitors from the industry and the union is liable with the employers if it becomes a party to the conspiracy.[24]

The same principles, we believe, apply to the "business of insurance" exemption under the McCarran-

[23] *Mackey* v. *National Football League*, 543 F. 2d 606, 612 (C.A. 8), certiorari dismissed, 434 U.S. 801, and other cases cited by petitioners (Br. 36), are not to the contrary. They merely recognize that, if an agreement is exempted from the antitrust laws by the labor exemptions, neither party to the agreement is liable under the antitrust laws. They also recognize, however, that both the union and employer groups lose any immunity when the union conspires with employers for the purpose of restraining trade in the employer industry.

[24] The same principles have been applied in the case of the antitrust exemption for agricultural organizations under Section 1 of the Capper-Volstead Act, 42 Stat. 388, 7 U.S.C. 291. *Case-Swayne Co., Inc.* v. *Sunkist Growers, Inc.*, 389 U.S. 384, 395; *National Broiler Marketing Association* v. *United States*, No. 77-117, decided June 12, 1978, slip op. 6 n. 11.

Ferguson Act, although the statutory exemption is cast in somewhat different terms. When insurers agree among themselves about matters concerning the relationship between insurers and insureds, the McCarran-Ferguson Act exempts such agreements from the antitrust laws to the extent they are regulated by state law and to the extent they do not constitute "boycott, coercion, or intimidation" within the meaning of Section 3(b). But agreements between insurance companies and other entities that restrain competition outside the insurance market are no more entitled to antitrust immunity than union-employers agreements designed to force certain employers out of business or to fix the price of goods and services other than wages and conditions of employment. In either case, the fact that such an agreement may affect wages (or insurance premiums) because it affects the flow of income to the employer (or insurer) is irrelevant.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY
also known as BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as
ROYAL PHARMACY OF CASTLE HILLS and
DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR THE INTERNATIONAL UNION, UAW, and the AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS AS AMICI CURIAE

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On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF FOR THE INTERNATIONAL UNION, UAW, and the AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS AS AMICI CURIAE

The filing of this brief as *amici curiae*, in support of Petitioners, has been consented to by all the parties under Rule 42(2) of this Court.[1]

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[1] *See:* Letter to Mr. Rodak, dated April 10, 1978, from counsel for petitioners and respondents.

QUESTION PRESENTED

Does "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), include "participating agreements," *i.e.*, direct contractual arrangements between an insurer and third party provider to supply benefits owed to the insurer's policy holders, where such arrangements are required by the insurance policy.

INTEREST OF AMICI

The UAW is an industrial union representing about 1.4 million workers, and their families, in the automobile, agricultural implement, aerospace, and other industries.

The AFL-CIO is a federation of 109 national and international unions, having a total membership of approximately 14 million workers.

The UAW and the AFL-CIO have pioneered the development of fringe benefit programs, particularly in the health care area. In fact, the prescription drug program at issue here, including its relevant details, was taken directly from the drug program "invented" by the UAW and Ford Motor Company in the 1967 labor negotiations.[2] In 1967-1968 negotiations, this drug program, or one very much like it, was implemented in most of the automobile, agricultural implement, and aerospace industry. It has subsequently been extended to major segments of American industry.[3] This case threatens to unsettle drug programs currently protecting millions of workers and their families.

[2] Goldberg & Loren, *The UAW Negotiated Prepaid Prescription Drug Program*, NS12 J. Am. Pharm. Assn., 422-425 (1972). The reimbursement formula, and the requirement of "participating agreements" were agreed to in the UAW/Ford negotiations. Insurers were asked to supply coverage meeting those specifications.

[3] By 1971, the Rubber Workers, Amalgamated Meatcutters, Retail Clerks, and Teamsters had negotiated a similar drug program with employers. *Id.* at 423, 425. *See also:* Council on Wage and Price Stability, *Employee Health Care Benefits; Labor Management Innovations in Controlling Cost*, 41 Fed. Reg. 40299, 40395 (Sept. 17, 1976).

Respondents' attack is directed against the "participating agreement," the very feature of these programs designed to protect against the rising cost of health care benefits. Such an attack imperils a wide range of benefit programs, not just those covering prescription drugs. The "participating agreement" provides this protection, as well, in negotiated hospital, vision care, hearing aid, physician services, and dental plans. In the auto industry, for example, the use of "participating agreements" is very widespread, if not universal, in hospital, vision care, and hearing aid programs. They are least used in the dental program, but, even there, almost one-half of the beneficiaries of the GMC, Ford, and Chrysler dental programs are in states using "participating" dental agreements. The expanding area of group legal services may be expected to rely heavily on "participating" agreements.

"Participating agreements" play such a central role because, under state regulation, they have been effective. UAW analysis of national data *for 1975*, for the GMC-UAW drug plan puts the average total cost, to plan and participant, of a prescription billed by a *participating* pharmacy at *no more than $6.23*. The average total cost of prescriptions filled, in that year, at *non-participating* pharmacies within a worker's or retiree's area was *$10.63*. In *1976*, the most recent available year, the comparable costs were *$6.64* for a prescription from a *participating* pharmacy, compared to *$11.98* from a *non-participating* pharmacy. Data for the Ford and Chrysler drug programs, by UAW calculations, reveal similar cost differences.

These benefit programs, with their attendant "participating" agreements, are not unique to Blue-Cross/Blue Shield. Employers and unions have implemented

these programs, on the negotiated terms, through a wide range of carriers, varying from state to state and program to program, even with a single employer and union.

SUMMARY OF ARGUMENT

The complaint in this action asserts that the Pharmacy Agreement entered into between Blue Shield of Texas and "participating pharmacies" pursuant to Blue Shield's prepaid prescription drug program is in violation of the Sherman Act. The sole question decided by the Court of Appeals, and now before the Court, is whether the Pharmacy Agreement is part of the "business of insurance" within the meaning of the McCarran-Ferguson Act ("McCarran Act"), which makes the Sherman Act inapplicable to the "business of insurance" to the extent that business is regulated by state law, except in cases of "boycott, coercion, or intimidation."[4] On its face, this is a narrow question. A decision in favor of respondents will not necessarily result in a finding of antitrust liability. The merits of the substantive antitrust claim have not yet been addressed by the courts below. Conversely, a decision in favor of the petitioners, *i.e.*, a holding that the Pharmacy Agreement is part of the "business of insurance," will not in itself render the antitrust

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[4] The Court of Appeals decision was based solely on its determination that the activities challenged by respondents do not constitute the "business of insurance," which, in its words "obviates the necessity" for determining whether the activities were regulated by state law or were acts of "boycott, coericon, or intimidation." (556 F.2d at 1379, n.3). Although the court's opinion discusses state regulation, it does so in determining only the "business of insurance" issue. While the opinion also refers to the challenged activities as "economically coercive," it does so only in conclusory terms and without purporting to hold that the McCarran Act's exemption is inapplicable for that reason.

The opinion of the Court of Appeals persistently refers to the challenged activities as "price fixing." The substantive antitrust issue, however, was not before the court. Indeed, there has as yet been no discovery on the merits of the antitrust claim.

laws inapplicable. The Pharmacy Agreement might thereafter be held outside the scope of the McCarran Act on either of the two issues the Court of Appeals found unnecessary to reach, namely, that the Agreement was not regulated by state law, or was a form of "boycott, coercion, or intimidation."

While the issue now before the Court is not dispositive, its resolution in favor of the petitioners is of critical import to the continuing efforts of employers, unions, insurers, government bodies and a variety of others to control the rapidly escalating costs of health care, an escalation attributable in significant part to the pervasive impact of health insurance itself. Innovative efforts to utilize the health insurance mechanism to control the escalating costs of health care, and to reduce the impact which health insurance has with respect to these costs, are now underway under the continuing supervision of state regulation. Such efforts will be significantly retarded if, either by virtue of their very purpose—to control health care costs, or by virtue of the utilization of contracts between insurers and third party providers, these actions are not deemed to be part of the "business of insurance" within the meaning of the McCarran Act. Insurers, unions, management and others whose efforts to control costs are met by the hazards and uncertainties of antitrust actions, even in the face of state approval, will be reluctant to proceed. In addition, the federalization of these issues, which the interpretation of the Act urged by respondents will bring about, may itself serve as a deterrent to experimentation, and is inconsistent with the broad policy of the Act to leave the primary responsibility for the regulation of insurance to the states.

Recognition that the "business of insurance" encompasses cost-control programs of the type at issue here neither leaves the health care industry without adequate

competitive safeguards nor completely immunizes conduct of health insurers. The Act's antitrust exemption is conditioned upon a showing that the activities at issue are regulated by state law. The state may take whatever actions it deems necessary to correct what it views as anti-competitive practices. Also, practices properly characterized as acts of "boycott, coercion, or intimidation" are not exempt under the Act in any event. Finally, and perhaps most important, it is not in the economic interest of either the insurer or those whom it insures to engage in practices the effect of which is to create monopoly power in those who provide the very services for which they must pay. The self-interest of insured and their insurers is clearly in a competitive health care industry. They are not likely to act to the contrary.

ARGUMENT

The escalation of health care costs in recent times is a well known phenomenon. Over the last decade, the rise in such costs has far outstripped the rate of inflation in the economy as a whole. Expenditures for health care have more than tripled since 1965,[5] soaring from $39 billion in 1965 to almost $140 billion in 1976.[6] From 1975 to 1976 alone, the increase was more than $17 billion. In 1976, health care represented 8.6 percent of the Gross National Product, and it is now predicted that this figure will climb to 10 percent by the early 1980's.[7] Concern over the impact of these increasing costs on the consumer has risen as the costs themselves have risen. Unions and others negotiating health care benefits on behalf of groups of insureds are particularly concerned, as it

[5] All dates are fiscal years ending July 31.

[6] Gibson and Mueller, *National Health Expenditures, Fiscal Year 1976*, 40 *Social Security Bull No. 4*, (April, 1977) at 4.

[7] Council on Wage and Price Stability, Executive Office of the President, *The Problem of Rising Health Care Costs* 9 (1976).

becomes apparent that these increases make greater inroads on amounts otherwise available for wages or other benefits. As a result, labor unions, and the UAW in particular, continually seek ways to slow down the rise in health care costs.

A number of factors contribute to the dramatic rise in the costs of health care. As medical science progresses, medical advances become more technologically complex and more expensive. But a significant part of the cause of escalating costs is the peculiar nature of the health care industry, which differs in several respects from most industry. A major portion of the health care costs are paid not by those incurring such costs but by third parties, primarily insurers. Additionally, the provider of care, the physician, hospital, or dentist, determines the extent of demand. As a result, the usual pressures to minimize costs are reduced.

The health care industry is characterized by a system of third-party payments to providers on behalf of consumers. The third-party payers range from the government, through such programs as Medicare and Medicaid, to private insurers. In 1976, such third-party payments constituted 68 percent of total expenditures for personal health care.[8] Rising health insurance premiums, then, are the primary medium through which the consumer directly experiences the overall rise in the cost of health care. However, approximately 80 percent of health insurance premiums are paid through employment-related group insurance plans. Only 17.5 percent of these premiums are paid directly by individuals,[9] who may not be conscious of actual premium cost. In any event, at the time of any given medical need, the consumer is unaware of how to translate the specific cost to his in-

[8] *Supra* note 6, at 8.

[9] *Supra* note 7, at 5.

surance premium, and is inclined, if fully insured, to view the service or product as "free."

Unlike most industries, demand for health care services is determined not by the consumers of those services, but by the providers themselves. The physician, hospital, or dentist in most instances determines both the need for care and the extent and nature of the care. The consumer is often neither equipped nor inclined to buy more or less, or to shop to meet his needs.

Incentive to reduce costs in the health care industry is therefore minimized. The predominant incentives are in the direction of providing a greater quantity of service, rather than toward efficiency and cost reduction. With the rapid escalation of costs, cost control measures designed to deal with these inadequacies in the health care industry are being sought. With health insurance itself a significant cause of cost escalation, attention is focusing on utilization of that same mechanism as a means of cost containment. The prescription drug program, with its implementing participating pharmacy agreements, challenged by respondents, is but one example of the means being utilized.

The challenged program derived from the prescription drug program contained in the 1967 collective bargaining agreements between the UAW and domestic automobile manufacturers, a program which remains in current agreements. Continuing effort by the UAW to dampen the escalation of health care costs, through the prescription drug program, reflects the simple fact that every dollar spent by an employer for employee health care benefits comprises money diverted from wages and other benefits. Because of the dramatic increases in health care costs, a substantial part of the increases in

creasing health insurance premium benefits for which the Union has already bargained.[10] The Union is thus pressed to contain health care costs, and plays a major role in the development of health insurance plans consistent with this purpose. These efforts will be severely jeopardized by a determination that the program here attacked by respondents, based upon the very plan contained in the Union's own collective bargaining agreements, does not constitute the "business of insurance."

I.

The Decision of the Court of Appeals Fails To Recognize the Interest of Insurers and Insureds in Containing Health Care Costs And Is Contrary to this Court's Definition of the Term "Business of Insurance."

The Pharmacy Agreements with "participating pharmacies" here at issue were entered into pursuant to the prepaid prescription drug insurance policy approved by the Texas Commissioner of Insurance in 1974. The court below concluded that the Agreements, while "somewhat related" to the business of insurance, are not part of the business because the "relationship . . . is so attenuated." Specifically, the court held that under the standards established in *SEC* v. *National Securities, Inc.*, 393 U.S. 453 (1969), the Agreements do not relate directly to the relationship between the insurer and its insured, who "are basically unconcerned with the contract between the insurer and the Participating Pharmacy." (556 F.2d at 1381). It would appear, therefore, that any agreement

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[10] *See* Hospital Cost Containment Act of 1977: Hearings on S. 1391 Before the Subcomm. on Health and Scientific Research of the Senate Comm. on Human Resources, 95th Cong. 1st Sess. 219 (1977) (statement of Douglas A. Fraser, President, UAW). The cost of negotiated health care benefits for the automobile companies now exceeds one dollar per hour per employee. *Id.* at 645 (statement by Chrysler Corporation).

by an insurer to directly contract with and pay the provider, for the delivery of goods or services to insureds, in which the insurer sets the price it will pay, would not satisfy the "business of insurance" requirements of the McCarran Act, as interpreted by the Court of Appeals.

The scope of this holding may be illustrated by the alternatives available to insurers suggested by the court below. The Court of Appeals stated that the insurer's "sole obligation" is to assure that the insureds receive prescription drugs at no more cost than the drug deductible established by the policy. Presumably this obligation could be met by reimbursement of the insureds based upon the actual price paid by them, whatever that might be.[11] While this would assure that insureds did receive drugs without additional expense, it would leave the insurer in the undesirable position of insuring against risks with considerable uncertainty over its costs, and would in no way contribute to the control of costs of the insurer or of health care generally. To the extent the insured desires a policy which would minimize its costs, such an approach is unsatisfactory. Conversely, an insurer presumably could, as part of the "business of insurance," issue a policy which simply reimbursed at a fixed rate for each drug prescribed, without regard to the price actually paid by the insured. While this plan might meet a traditional standard of "insurance," and contribute to the control of the costs of the insurer and of health care generally, it would not satisfy the desire of

[11] In theory, this obligation could also be met if the policy called for reimbursement for drugs purchased only at pharmacies designated by the insurer, such pharmacies being selected for designation on the basis of a history of relatively low retail prices. If no contractual arrangements with providers existed, the rationale of the Court of Appeals might result in a conclusion that such a program was the "business of insurance," even though the economic impact on non-designated pharmacies might be the same as that alleged in respondent's complaint.

insureds to be insured against the risk of all drug expenses incurred as a result of illness. It would not satisfy the contractual policy requirements in the present case.

The Court of Appeals thus conceived the "business of insurance" as involving cash reimbursement of some or all of the expenses incurred when the risk insured against by the policy occurs. Where the insurer provides products and services the insurer has thus entered a different business, which can no longer be characterized as the "business of insurance." This misconceives the nature of the insurance business and the nature of the insurance obligation undertaken by the insurer in the present case. It fails to give adequate weight to the concern of both the insurer and insureds in containment of health care costs. And the court confused the substantive question of competitive effect with the initial "business of insurance" issue, suggesting that because there is an alleged anticompetitive effect outside the insurance business, the acts of the insurer are not the "business of insurance."

Insurance involves the "underwriting of risks" in exchange for a payment by the insured. See *SEC* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65, 72 (1959). In broad terms, health insurance in various forms insures against the risk of financial loss incurred in the treatment of illness and the attendant risk that the insured will be unable to obtain treatment because of financial inability. The prescription drug policy here at issue is but a specific example. The risk which the insurer underwrites is the risk of financial loss arising from the need to purchase prescribed drugs, and the possibility that such drugs might not be available as the result of financial inability to pay for them. The underlying policy obligates the insurer to enter into participating pharmacy agreements to assure the availability of drugs to its insured at no more than the $2.00 drug deductible charge. Such availability is one way in which the insurer meets

its obligations to underwrite the very risk which it has contractually undertaken through the policy. Whether that risk is satisfied through cash reimbursement, as in the case where a prescription is presented to a non-participating pharmacy, or through participating pharmacy agreements, the fact remains that the insurer has underwritten a specific risk on the basis of a premium paid, and is thus engaged in the "business of insurance." The fact that the insured *could* write a policy meeting the risk needs of its insureds in some other fashion is not a basis for concluding that its present decision is not the "business of insurance." Indeed, one of the critical business judgments within the insurance business is resolution of the very question of how the claims of insureds shall be satisfied. This is a judgment to be arrived at between the insurer and the insureds. It directly involves their relationship, and is thus a critical element of the "business of insurance." See *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969). How the insurer and insureds resolve this issue does not make the business involved something other than insurance.[12]

Recognition of the interest of both insurers and their insureds in effectively containing the costs of health care generally, and health insurance in particular, is central for resolution of the issue before the Court. The insurer desires to contain its costs to remain competitive with other insurers. The insureds, whose premiums directly reflect medical care costs, have an obvious interest, as already noted. The insurance policy between the two, both in terms of basic coverage and the means of satisfying the claimant once the risk insured against has occurred, will reflect the desire of both to contain costs. The insurer, who is ultimately in the business of meeting

[12] These arguments are advanced in more detail by petitioners, and are therefore made in summary fashion here.

the risk underwriting needs of its customers, the insureds, for a price must satisfy those needs. To the extent that insureds desire cost containment measures of the type here involved, the insurer must be in a position to meet those needs. As already indicated, unions and other groups acting on behalf of their members do have a direct concern with cost containment, and have worked directly with insurers to develop programs within the framework of health insurance to develop effective cost control methods.

The Court of Appeals, however, did not consider cost containment to be a goal of any significance to the question before it. It suggested that the insurer's desire to "protect itself and its customers" from rising costs "does not transform the Pharmacy Agreement into the business of insurance," and that the "best way for the firm to protect itself from rising costs is to establish and periodically adjust its rate structure to reflect the impact of inflation." (556 F.2d at 1382). Adjustment of rates may be difficult if rates themselves are directly regulated, but more important, such adjustment would do nothing to contain costs, either to the insurer, its insureds, or the public generally. Indeed, a series of automatic rate adjustments would simply assure that escalating costs are passed on to the ultimate consumer.

The desire of Blue Shield, and other insurers, to devise insurance plans which contribute to cost containment cannot be so cavalierly dismissed. The insurer's business is to meet the desires of its insureds, and to the extent the insureds seek both full cost coverage and lower insurance rates through direct provision of services, utilizing third-party contracts of the type at issue here, satisfying those desires is a direct and integral part of the "business of insurance" and cannot be divorced from it. This is not transformation of the participating pharmacy agreements into something they are not, but recognition of their cen-

tral role in the relationship between the insurer and its insureds, as well as in the determination of rates, as central features of the "business of insurance."

Of course, not every act done by an insurer to reduce its costs must be regarded as part of the "business of insurance," even though all cost reduction may benefit the insureds indirectly through the premium rates set by the insurer.[13] But where the insurer acts to contain the costs of the very services and products whose purchase is the risk underwritten, control of those costs cannot functionally be viewed as separate from the insurance obligation itself.

II.

A Determination that Petitioners' Activities Do Not Constitute the "Business of Insurance" Will Significantly Impair Development of Prepaid Health Care and Health Insurance Plans Utilizing Third-Party Providers, and Insurance Programs Designed to Contain Health Care Costs.

A decision that the challenged Pharmacy Agreements between the insurer and "participating pharmacies" are

[13] If the actions taken by the insurer are not in fact an attempt to control costs, but are instead simply a capitulation to a cartel of providers who by virtue of their bargaining power can impose their own will on the insurer, the actions may not truly be the "business of insurance" at all. The result of such a cartel would be enhancement of the costs of goods and services contrary to the interests of the insurer and its insureds, and would not be part of their direct insurance relationship. *Compare Continental T.V., Inc.* v. *GTE Sylvania, Inc.*, 433 U.S. 36 (1978), where in holding that so-called vertical territorial restrictions imposed by manufacturers on their distributors were not a *per se* violation of the Sherman Act, the Court noted that if such restrictions originated in a cartel of the distributors themselves, the conduct would constitute a *per se* violation. Conversely, if the "participating pharmacy" agreements at issue here are held the "business of insurance" by the insurer, it would be anomolous to hold third parties who did no more than sign such agreements outside the scope of the McCarran-Ferguson Act exemption. This issue is discussed in detail by petitioners.

not an integral part of the "business of insurance," and thus outside the McCarran Act's antitrust exemption will significantly retard the development of a variety of prepaid health care and health insurance plans which, like the program at issue here, involve the use of third-party providers, and will seriously impair the utilization of the health insurance mechanism to control health care costs. The constant threat of antitrust litigation will chill enthusiasm for such programs. And the federalization of these issues which will result will deprive the states of the regulatory flexibility needed to encourage such innovative efforts.

Full application of the antitrust laws to health insurance activities involving third-party providers poses the threat of treble damage liability which may be imposed in private antitrust litigation if the challenged conduct in fact violates those laws. Pending case-by-case determination, the manner in which the antitrust laws apply to such programs is highly uncertain. One need only compare the opinion of the court below, which persistently characterized the insurer's conduct as price fixing, with the views of the Justice Department's Antitrust Division,[14] which concluded that it would not challenge a prepaid prescription similar to the program here at issue, to perceive the uncertainty which exists. Further, the active supervisory and regulatory role played by the states compounds the issue of antitrust liability. Whether conduct by health insurers violates the antitrust laws rests not only upon application of traditional substantive

[14] Business Review Letter from Assistant Attorney General Donald Turner to Gerald R. Goodell, Esq., dated January 15, 1968. (App. B. Amicus Curiae Brief of Blue Shield Association in Support of the Petition for Certiorari).

antitrust standards, but also on an assessment of the pervasiveness and nature of state regulation.[15]

The range of factors potentially affected by application of the antitrust standards is itself great. At issue in the present proceeding is the liability not only of Blue Shield, the insurer, but of those providers who signed the participating pharmacy agreements.[16] Health insurance plans may also be the result of collaboration between the insurers and their insureds, or may be derived from collective bargaining agreements. Unions, management, and other groups of insureds who contribute to the formulation of health care plans may perceive a risk that they may be held to have combined or conspired with the insurers,[17] and thus are directly subject to antitrust

[15] The Court of Appeal's opinion suggested that if the McCarran Act exemption is inapplicable to the challenged activities, the antitrust laws are fully applicable (556 F.2d, at 1380). However, the question of antitrust liability where the appropriate state regulatory authority has mandated, approved, encouraged or otherwise participated in these activities would still presumably be governed by the standards contained in this Court's opinion in *Cantor* v. *Detroit Edison Co.*, 428 U.S. 579 (1976).

[16] The Court of Appeals concluded that petitioner pharmacies are not within the McCarran Act, but its rationale is not clear. If the court only means that the pharmacists who signed the Pharmacy Agreements are not exempt because the activities themselves are not exempt, the ruling simply makes the exemption question the same for all petitioners. If, however, the court means that the pharmacies are not exempt even if the use of such agreements by Blue Shield is the "business of insurance," the inability of direct providers to participate will itself deter, or eliminate, plans of this type. The independent liability of the pharmacists is discussed in detail by Petitioners.

[17] In *Ackerman-Chillingworth, Division of Marsh & McLennan, Inc.* v. *Pacific Electrical Contractors Ass'n.*, —— F.2d —— (9th Cir. 1978), 76 DLR D-1, suit was filed against, *inter alia*, union and management associations challenging as a boycott in violation of the Sherman Act a union-management agreement to handle workmen's compensation insurance through a single group plan, to the exclusion of plaintiff insurance agent and others. The court affirmed a summary judgment in defendants' favor on the merits,

liabiilty in suits filed by disaffected third parties. Finally, a large number of private plaintiffs, providers who are not participants in particular plans or who find the terms on which they are permitted to participate unsatisfactory, as appears to be the situation in the present case, will find the threat of antitrust litigation in their interest. Because the markets in which they operate tend to be local in nature, and because the health care plans as implemented may vary significantly from state to state, a given insurer and other potential defendants face the risk of a large number of relatively localized suits, with varying results.

Irrespective of the outcome on the merits, the threat of private antitrust litigation, with its attendant costs, delays and potential dollar liability exposure, will thus deter from involvement at least some of those whose cooperation is essential to the development or implementation of third-party provider health care plans or other insurance plans seeking to contain costs, at the very time escalation of health care costs are of major national concern. Even if insurers are satisfied that their actions do not run afoul of the antitrust laws, insureds and third-party providers, whose contributions are essential, may perceive their risks differently and decline to participate. Activities necessarily involving a large number of participants for success are peculiarly vulnerable to the threat of antitrust litigation.

Active participation by state regulatory bodies, a past source of stimulus to innovation, may also be frustrated should the Court affirm the narrow interpretation of "business of insurance" adopted by the Court of Appeals.

with one judge dissenting except as to certain insurance company defendants. It did not reach the McCarran Act exemption and the labor exemption, issues which had been raised. Where the challenged program is the result of collective bargaining, the labor exemption may provide some protection to unions and management.

Presumably, the state and its agencies will not be the subject of antitrust liability however the "business of insurance" is resolved. *Parker* v. *Brown*, 317 U.S. 341 (1943). But the ability of these agencies to secure cooperative responses from insurers to regulatory initiatives will depend on the insurers' assessment of the risks of doing so. Caught between regulatory desires and the risk of potential antitrust liability, insurers may conclude that the latter risks are simply too great. Third-party providers and insureds may decline cooperation for the same reason.

The McCarran Act places primary responsibility for the regulation of insurance in the states. *See Prudential Ins. Co.* v. *Benjamin*, 328 U.S. 408, 429-430 (1946). The Act's antitrust exemption is but one aspect of this broader purpose. The federalization of standards, which would necessarily result from the construction of "business of insurance" adopted by the Court of Appeals, will subject the states to a series of constraints impairing the effectiveness of their regulatory authority, contrary to this broad purpose. A state may conclude that federal antitrust laws *should* be applicable to a particular activity of the insurance industry. If so, the states may as a practical matter subject such an activity to the antitrust laws by not regulating it. The narrow reading of "business of insurance" urged by respondents would deprive the states of this election with respect, at least, to third-party providers, and instead make federal antitrust standards mandatory, depriving the states of regulatory flexibility in devising and supervising a variety of means of providing health care services at reasonable cost.

The flexibility of the state regulatory process, and the variant patterns of regulation and state interests from state to state, have permitted a range of experimentation with innovative prepaid health care plans and health in-

surance programs involving third-party providers. Consider, for example, the role played by the state in the insurance program involving third-party providers held to be within the McCarran Act in *Travelers Insurance Co.* v. *Blue Cross of Western Pennsylvania*, 481 F. 2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093 (1973). Imposition of a single, federal antitrust standard will threaten conformity, and tend to stifle such innovative efforts.

Application of federal antitrust standards to provider agreements entered into pursuant to health insurance policies, including prescription drug policies, bifurcates the regulatory process. If a state regulatory body concludes that regulation of the agreements is an essential element to regulation of the policy, or of rates to be charged, imposition of a single federal standard to part, but not all, of what the state deems a single, interrelated set of transactions will jeopardize its ability to deal comprehensively with the issues as a whole. Thus, while interpretation of the statutory phrase "business of insurance" is a question of federal law, the views of the appropriate state regulatory agency that a particular activity is so directly related to the insurance process as to constitute the "business of insurance" is entitled to considerable weight. *See SEC* v. *Variable Annuity Co.*, 359 U.S. 65, 65 (1959). Whether the Texas State Board of Insurance and Attorney General have viewed the provider agreements challenged by respondents as part of the "business of insurance" is disputed, but they appear to have done so. The exertion of regulatory supervision over the prescription drug policy and implementing provider agreements by the Texas Commissioner rests on the direct relationship between them, and is a significant factor in resolving the issue.

III.

Interpretation of the McCarran Act's "Business of Insurance" Requirement To Encompass The Challenged Activities Is Not Inconsistent With the Preservation of Competition in Health Care Provider Markets.

As this Court has said, "competition is our fundamental national economic policy . . ." *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 372 (1963). Exemptions from the antitrust laws, which reflect that policy, are not therefore lightly implied. *Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. 213, 218 (1966). Specific exemptions are to be construed in light of a presumed Congressional intent to reserve competition where possible, consistent with the overall intent of the exemption. Relevant to the construction of any antitrust exemption, therefore, is the extent to which adequate safeguards against anti-competitive conduct will remain even if the challenged activities fall within the reach of the exemption.

A determination that the activities of respondents challenged here are within the McCarren Act's definition of the "business of insurance" will not leave insurers, providers or others free to engage in anti-competitive conduct which significantly restrains competition in health care markets, the concern of the Court of Appeals. The Act's exemption is not absolute. Conduct which takes the form of "boycott, coercion or intimidation" is expressly excerpted from the exemption, and is thereby directly subject to the antitrust laws even where the "business of insurance" standard is met.[18] Whatever the nature of the challenged activities, the exemption is applicable only

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[18] The meaning of the "boycott" exception is at this writing before the Court in *St. Paul Fire & Marine Insurance Co.* v. *Barry*, No. 77-240, October 1977 Term, and will not be addressed here.

to the extent the insurance business is regulated by state law. Consistent with the broad purpose of the McCarran Act to place primary responsibility for the regulation of insurance in the states, the states have both the authority and responsibility to deal with anti-competitive conduct inconsistent with their own regulatory schemes. A state may deal with such conduct through its regulatory process, or could elect to rely on the provisions of its own antitrust law should it find that appropriate. Indeed, by simply not regulating the activities in question, the state, as a practical matter, could make the conscious determination to rely on the federal antitrust laws. The states are thus hardly powerless to act to prevent anti-competitive conduct by insurers and those acting in concert with them.

The ultimate safeguard, however, against conduct by insurers which restrains competition in health care provider markets is self-interest. Not only do the insurers and insured have no economic interest in restraining competition in the very markets where they must purchase, or reimburse purchases, it is contrary to their economic interest to do so. The Court of Appeals characterized the petitioners' activities as a boycott, foreclosing non-participating pharmacies from the market. The competitive danger of such foreclosure is the creation of monopoly power in the participating pharmacies. But the Court of Appeals never questions why the insurer would have any economic interest in the creation of such power. The inevitable consequence would be an increase in the price of prescription drugs, a result hardly in the interest of either the insurer or its insureds. Just as a manufacturer of goods will normally find the creation of monopoly power in those who distribute its goods contrary to its own economic interest, *see Continental T.V. Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36, 56 (1977), so

too creation of monopoly power in suppliers is against the economic interest of those purchasing from them.[19]

The states have adequate power to deal with any anti-competitive conduct by insurers, providers and others engaged in the "business of insurance." And interpretation of the McCarran Act's "business of insurance" standard to encompass health insurance plans utilizing third-party provider agreements as a means of satisfying the claim of insureds poses no threat of monopoly power in health care provider markets.

CONCLUSION

For the foregoing reasons, we urge the Court to *reverse* the decision of the Fifth Circuit.

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[19] The creation of monopoly power would be in the interest of health care providers, who might impose a cartel agreement among themselves on an otherwise unwilling insurer with insufficient strength to resist. Such an arrangement can be distinguished from legitimate cost containment measures, *cf. Continental T.V. Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36, 58 n. 28 (1977), and need not be viewed as the "business of insurance." See note 13 *supra*.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, et al.,
Defendants-Appellants.

vs.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, et al.,
Plaintiffs-Appellees.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

AMICUS CURIAE BRIEF OF THE BLUE SHIELD ASSOCIATION

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GROUP LIFE AND HEALTH INSURANCE COMPANY,
also known as BLUE SHIELD OF TEXAS, et al.,
Defendants-Appellants.

vs.

ROYAL DRUG COMPANY, INC., doing business as
ROYAL PHARMACY OF CASTLE HILLS
and DISCO PRESCRIPTION PHARMACY, et al.,
Plaintiffs-Appellees.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

AMICUS CURIAE BRIEF OF THE BLUE SHIELD ASSOCIATION

Blue Shield Association ("BSA"), a nonprofit association of seventy nonprofit medical prepayment plans located throughout the United States, submits this brief as *amicus curiae* in support of the defendants-appellants' request to reverse the judgment of the United States Court of Appeals for the Fifth Circuit and affirm the judgment of the United States District Court for the Western District of Texas in this case. This brief is filed with the consent of all the parties. (See Appendix A.)

THE INTEREST OF THE *AMICUS CURIAE*

More than 85 million persons in the United States were served by sixty-nine Blue Shield Plans* in both private and government business during 1976. In 1976 alone, Blue Shield Plans paid out more than $8 billion in medical benefits for their subscribers. Blue Shield Plans are nonprofit and belong to the Blue Shield Association, a nonprofit organization which, among other things, administers the various Membership Standards relating to containment of health care costs.

More than seven million subscribers of Blue Shield and Blue Cross Plans nationwide have coverage under out-of-hospital prescription drug insurance programs which contain provisions similar to those challenged in this case. The Plans processed more than thirty million claims and paid out over $165 million in benefits under these programs during 1976. A substantial proportion of the claims and benefits were covered pursuant to a collective bargaining agreement between the United Automobile Workers and the domestic automobile manufacturers; forty-two Plans processed claims under the automobile industry program.

The drug program operates in a manner which permits market forces in the retail drug industry to determine the price of a retail prescription while enabling the Plan to predict and control the total cost of the program to the subscribers as a whole. The Fifth Circuit's repeated characterizations of the program as "price-fixing" reveal a misunderstanding of the

* Appendix B to the attached brief lists the seventy Blue Shield Plans in the United States. One Plan was added in 1978.

program's operation. It is therefore essential to explain at the outset how the program works and how it was developed.

Pharmacies which wish to participate in the program sign a "participating pharmacy agreement." A participating pharmacy is reimbursed by the Plan in an amount equal to the acquisition cost of the drug, *plus* a dispensing fee, *minus* the amount of any deductible. The participating pharmacy, in turn, agrees not to charge subscribers more than the deductible, if any. Pharmacies are free to charge subscribers the full amount of the deductible (for example, $2.00) or only a portion of the deductible (for example, $1.00), or nothing at all.

It may be useful to consider each of these three components separately. The first component, the acquisition cost, is merely the price paid by the pharmacist for the drug and is not affected by the Plan or the participating pharmacy agreements. *Cf.* U.S. Dep't of Health, Education, & Welfare, Task Force on Prescription Drugs, *Background Papers: Approaches to Drug Design* 18 (1969) (acquisition cost basis for reimbursement does not interfere with present marketing and pricing systems) (hereinafter "HEW Task Force"). Most agreements do, however, permit the Plan to monitor these charges to be sure that it is being charged the amount the pharmacist actually paid for the drug. (See Prototype Agreement, Appendix C.)

The second component, the dispensing fee, is merely a unilateral offer from the Plan to each pharmacy to provide services for a specified price. On the assumption that some pharmacies may elect not to discount the deductible at all, the Plan calculates the dispensing fee so as to make it advantageous for most pharmacists to participate in the program. An individual pharmacy,

like any seller, will accept the Plan's offer to participate only if it considers the offer to be economically desirable. Plans periodically adjust the dispensing fee to continue to attract a sufficient number of participating pharmacies.

The third component, the deductible, is determined by the insurer and the insured and depends, in part, on the total amount the customer is willing to pay for the insurance. *Problems on Third Party Prepaid Prescription Programs: Hearings Before the Subcomm. on Environmental Problems Affecting Small Business of the House Permanent Select Comm. on Small Business*, 93d Cong., 1st Sess., 102-03, 205 (1973) (hereinafter "1973 Hearings") (testimony of Donald G. Puscas).* The extent to which the deductible is discounted by the pharmacy is determined in the marketplace. By discounting the deductible, pharmacists can and do compete for the business of Plan subscribers just as they compete for the overwhelming proportion of prescriptions which are not covered by insurance.**

There is thus no "retail price" for prescription drugs dispensed by participating pharmacies under this

* The amount the customer is willing to pay for the program is itself, of course, determined in a competitive market. Efficient insurers who have lower overhead costs and are able to offer more benefits for the same rate (or the same benefits at a lower rate) will get more business.

** Goldberg & Loren, *The UAW Negotiated Prepaid Prescription Drug Program*, NS12 J. Am. Pharm. A. 422, 425 (1972) ($2.00 copayment discounted to 89 cents in some areas) (hereinafter "Goldberg & Loren"). For example, a discount of $0.50 from the most common deductible of $2.00 can save a Plan subscriber 25 percent of his out-of-pocket cost, which also constitutes almost 10 percent of the $5.66 average cost of prescriptions filled at retail pharmacies in 1976. Eli Lilly & Co., *Lilly Digest: A Survey of Community Pharmacy Operations for 1976* 26 (1977) (average cost of prescriptions).

program. Rather, a Plan's subscribers are entitled to receive covered prescription drugs in return for paying a premium, subject only to the payment of a deductible which may be discounted.

Alternatively, a subscriber may elect to purchase drugs from a "nonparticipating pharmacy," in which event the subscriber pays the pharmacy the full prescription price and files his own claim with the Plan. He is reimbursed for a specified percentage (commonly 75 percent) of the pharmacy's "usual and ordinary" charge in excess of the applicable deductible. (See Prototype Agreement, Appendix C.) The out-of-pocket cost is usually less for a subscriber who has a prescription filled at a participating pharmacy. The Plans' prescription drug reimbursement mechanism therefore provides an incentive for each subscriber to patronize participating pharmacies. The reason for this is simple—the Plans' costs of reimbursing participating pharmacies are generally lower than direct reimbursement of each subscriber, so this incentive is designed to help keep premium rates down.

The challenged reimbursement mechanism is universally regarded as a sound cost containment device. Indeed, the Department of Health Education and Welfare has specifically approved this reimbursement formula for drugs used in federal programs it funds and administers. Almost every state government uses the acquisition cost plus dispensing fee formula to reimburse pharmacists who provide drugs under Medicaid. The same formula is employed by the Department of Defense in its CHAMPUS (Civilian Health and Medical Program for the Uniformed Services) program, and the formula also appears in programs offered by commer-

cial insurers and those required by numerous collective bargaining agreements.

Blue Shield and Blue Cross Plans' prescription drug programs were first implemented in the late 1960's as a result of the collective bargaining agreement between the United Automobile Workers and the domestic automobile manufacturers. Because no one had previously attempted to calculate a dispensing fee, the Michigan Plan undertook an extensive study of current prices and published data pertaining to pharmacies' operations and costs in Michigan. As a result of this study, the Plan determined to offer an initial dispensing fee approximately 10 percent higher than the "average" dispensing fee, calculated using empirical data reflecting the costs of providing the customary level of services for most pharmacies (such as record-keeping, delivery, and emergency and consulting services).

Of necessity, the Michigan Plan and other Blue Shield and Blue Cross Plans calculate their dispensing fees so as to satisfy the varying needs of many different types of pharmacies. Blue Shield and Blue Cross Plans' prescription drug programs account for less than 2 percent of all retail drug sales in the United States. If the Plans' dispensing fees were unrealistically low, pharmacies could elect not to participate.

Finally, it should be emphasized that Blue Shield and Blue Cross Plans are nonprofit organizations dedicated to serving the public. The pharmacy agreements challenged in this lawsuit were designed specifically to contain costs, insofar as feasible, for the ultimate benefit of patients and subscribers. Any increase in costs which might result from the decision below would, ultimately, be borne by the consuming public generally.

SUMMARY OF ARGUMENT

The Fifth Circuit's restrictive concept of the "business of insurance" includes relationships between the insurer and the insured, while excluding agreements between the insurer and the provider of services. The court below presumes that the efforts of the states and insurers to control costs (by regulating insurer-provider agreements) have no place in the "business of insurance." In stark contrast, however, state and federal regulatory and judicial authorities unanimously agree that cost containment is an essential activity, if not a fundamental responsibility, of the "business of insurance."

Moreover, numerous state and federal officials have recognized that agreements between insurers and providers, and in particular the pharmacy agreements in this case, effectively control the costs upon which premium rates are based. Therefore, the pharmacy agreements unquestionably constitute the "business of insurance."

The Fifth Circuit's decision, which does not consider these fundamental characteristics of health insurance, would create almost insurmountable obstacles to effective state regulation. By subjecting the insurer-provider relationship to the federal antitrust laws, while leaving the integrally related insurer-insured relationship to the demands of state regulatory policies, the decision below would interfere with state regulation of both relationships and place the insurer in the untenable position of attempting to comply with potentially conflicting policies.

The Fifth Circuit apparently failed to appreciate the consequences of its piecemeal application of the McCarran-Ferguson Act, perhaps as a result of a misunderstanding of the operation of the prepaid drug program in general and of the pharmacy agreements in particular. The characterization of the pharmacy agreements as "price-fixing", 556 F.2d at 1381, conflicts with the assessments of various Department of Justice officials who followed the development of prepaid drug programs and who specifically reviewed similar agreements pursuant to the Department's Business Review Procedure.

ARGUMENT

I.

THE "BUSINESS OF INSURANCE" INCLUDES COST CONTAINMENT EFFORTS.

The Fifth Circuit's narrow focus on the relationship between the insurer and the insured failed to take account of the realities of efficiently providing health insurance benefits to millions of Americans in today's marketplace. In particular, the Fifth Circuit failed to recognize that there are at least three parties—not two—who play crucial roles in the health insurance industry: the insurer, the insured, and the provider of health care services. The Fifth Circuit excluded from the "business of insurance" insurer-provider agreements used to control and predict costs. Thus, the Fifth Circuit reached the startling conclusion that cost containment has no place in the "business of insurance" at a time when state and federal authorities across the country are concentrating their efforts on controlling the costs of health insurance. 556 F.2d at 1382.

Unlike the many responsible authorities who urge the Plans to control costs, the Fifth Circuit said that a Plan's obligation as an insurer is solely to pay health care providers *whatever* they charge:

> Just as the automobile insurer is obligated to pay the cost of repair, *whatever it might be*, over and above the applicable policy deductible, Blue Shield is obligated to pay the cost of prescription drugs. . . .

556 F.2d at 1381.* If health care costs were to increase radically as a result of the imposition of a passive reim-

* Unless otherwise indicated, all emphasis in this brief has been added.

bursement policy, state insurance commissioners and health insurers should, according to the Fifth Circuit's directive, merely "establish and periodically adjust . . . [the] rate structure to reflect the impact of inflation." 556 F.2d at 1382. The rejection of cost containment as a legitimate and indeed necessary aspect of the "business of insurance" would disregard the purpose of the McCarran-Ferguson Act and propel the federal courts headlong into the business of insurance rate regulation, the very core of the state-regulated insurance business.

The following discussion will demonstrate that the Fifth Circuit's analysis of the "business of insurance" is fatally deficient in several respects. First, mechanisms designed to minimize health insurance premiums by containing costs are a fundamental aspect of the "business of insurance." Second, agreements between insurers and providers of health care services, such as pharmacy agreements, are a widely recognized, effective mechanism for controlling health care costs. Third, agreements between an insurer and a provider of health care services, which enable insurers to charge lower rates based on reliable cost predictions, unquestionably constitute the "business of insurance." Fourth, application of the federal antitrust laws to insurer-provider agreements would impair state regulation of the insurance business and insurers' compliance with state regulatory requirements.

A. Mechanisms Designed To Minimize Costs Are An Essential Aspect Of The "Business Of Insurance."

Contrary to the Fifth Circuit's view, Blue Shield Plans, state regulatory authorities and, indeed, the federal courts, see cost containment as a fundamental aspect, if not a primary responsibility, of the "business

of insurance." Joseph A. Califano, Jr., Secretary of the United States Department of Health, Education, and Welfare, and William Lilly III, former acting director of the President's Council on Wage and Price Stability, have contended that one reason costs have risen so drastically is that health care providers are allegedly unresponsive to market demands. *See Curbing the Cost of Health Care*, Bus. Week 82 (April 4, 1977). Representatives of all segments of society are calling on third party payors such as Blue Shield Plans *to control these costs* through provider reimbursement mechanisms. *See, e.g.*, Herzlinger, *Can We Control Health Care Costs?*, 56 Harv. Bus. Rev. 102, 108-09 (1978) (Assoc. Prof. Bus. Adm., Harvard Bus. School); Council on Wage & Price Stability, *Employee Health Care Benefits: Labor-Management Innovations in Controlling Costs*, 41 Fed. Reg. 40298 *et seq.* (1976); Bailey, *Rising Health Care Costs—a Challenge to Insurers*, Nat'l J. 608 (May 1, 1976) (President, Aetna Life & Cas.); Zink, *Greater Effort Needed to Control Costs*, 50 Hosp. 65 (March 16, 1976) (Director, Employee Benefits and Services, General Motors Corp.); *Commercial Health and Accident Insurance Industry: Hearings Before the Subcomm. on Antitrust and Monopoly of the Senate Comm. on the Judiciary*, 92d Cong., 2d Sess., Part 1, 387 *et seq.*, (1972) (statement of Herbert S. Denenberg, Insurance Comm'r for State of Pennsylvania).

Blue Shield Plans have long regarded cost containment as a primary responsibility of their business. Accordingly, the Plans have adopted a variety of cost containment programs which have resulted in savings of millions of dollars for their subscribers. In 1977 alone their utilization and peer review of claims submitted by

providers resulted in a savings of more than $22.9 million. Their usual, customary and reasonable ("UCR") reimbursement mechanism to providers resulted in a reduction of more than $370.9 million in providers' charges to the Plans. Other programs such as coordination of benefits resulted in a saving of more than $45.0 million to their subscribers. A Director of Insurance Economics at the Chase Econometrics Insurance Forecasting Service recently reported that an industry-wide adoption of the Blue Shield guidelines on obsolete medical procedures could result in a total savings of $78.0 million to United States insurance companies. *See Ins. Advocate* 14 (July 23, 1977). One of the Membership Standards administered by BSA specifically requires Blue Shield Plans to develop effective cost containment programs and BSA is actively monitoring the Plans' compliance with that standard.

State statutes regulating the Plans give the state insurance commissioners extensive authority over cost containment efforts through their regulation of premium rates, benefits, and provider reimbursement levels. These statutes often require the insurance commissioners to fix or approve the premium rates charged and the contracts issued to the Plans' subscribers. *See, e.g.*, Conn. Gen. Stat. 1975, § 33-172; Kan. Stat. Ann. § 40-1906 (1973); N.M. Stat. Ann. § 58-25-16, § 58-25-17 (Supp. 1975). In addition, many state statutes contemplate that the Plans will enter into agreements with providers or groups of providers who agree in advance to render services to the Plans' subscribers for a certain amount or reimbursement method approved by the state insurance commissioners. *See, e.g.*, 40 Pa. S. § 1558 (Supp. 1977); Fla. Stat. Ann. § 641.03 (1972); Mass. Ann. Laws ch. 176B, § 4 (1977). Frequently, other aspects of

the Plans' contracts with providers must conform to various state statutory requirements. *See, e.g.*, Md. Code Ann. Art. 48A, § 355(b)(2) (Supp. 1977); Calif. Health & Safety Code § 1367(h) (West Supp. 1978). Beyond the authority over rates charged and contracts issued to providers and subscribers, the state insurance commissioners often have substantial power to conduct sweeping investigations of Plans and to alter almost *any* aspect of the Plans' operations. *See, e.g.*, Ill. Rev. Stat. 1975, ch. 32, § 557; N.Y. Ins. Law § 251 (McKinney 1966); Utah Code Ann. § 31-37-21 *et seq.* (Supp. 1973).*

Armed with the foregoing extensive regulatory authority, state insurance commissioners throughout the country have regarded cost containment as one of their primary responsibilities in regulating the business of health insurance. For example, former Pennsylvania Insurance Commissioner Herbert S. Denenberg told the Senate Subcommittee on Antitrust and Monopoly a few years ago:

> Since January 1971, we have been able to clearly identify the contribution of Blue Cross and Blue Shield to cost and quality control. . . .
>
> These controls call for the elimination of unsafe and unnecessary facilities; the use of generic drugs rather than their more expensive brand name equivalents; limitations on payments for interns and residents; more precise accounting methods; protection of patients from being charged for services deemed medically necessary [*sic*]; hospital safety programs to protect patients from needless injuries; and many other reforms. . . .

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* For a general discussion of the states' regulation of Blue Shield Plans, see the statement of the former Executive Director of the National Association of Insurance Commissioners, *National Health Insurance Proposals: Hearings before the House Comm. on Ways and Means*, 92d Cong., 1st Sess., Part 2, 406-07, 429 (1971).

. . .

> Other experiments in cost control through reimbursement are being carried out by other Blue Cross plans across the United States.
>
> We have asked the commercial insurance companies to document their cost and quality control measures.

Commercial Health and Accident Insurance Industry: Hearings Before the Subcomm. on Antitrust and Monopoly of the Senate Comm. on the Judiciary, 92d Cong., 2d Sess., Part 1, 388-389 (1972).

Other state insurance commissioners' vigorous regulation of health insurers' cost containment efforts indicate that they too regard cost containment as an essential activity of the "business of insurance". For example, in 1974 Vermont's Insurance Commissioner held hearings into the efforts of his state's Blue Cross Plan to "help keep down hospital costs" and ordered the Plan to improve its procedures for reviewing whether or not persons should be hospitalized. *Ins. Digest* (Aug. 24, 1974). The Florida State Insurance Commissioner recently called upon the Florida Plans to work even more diligently in the area of cost containment. Florida, Office of the Treas., Ins. Comm'r, *Order re Approval of Increase in Rates* 7, Case No. 77-Rate-09H (filed Nov. 23, 1977). Insurance commissioners in Illinois, New York and Michigan have also issued various directives ordering the Plans to implement certain cost containment programs. Illinois, Dep't of Ins., *Order re Proposed Rate Revisions*, Hearing No. 1607 (filed April 8, 1978); New York, Sup't of Ins., *Opinion & Decision re Blue Cross of Northeastern N.Y., Inc.* (effective Jan. 1, 1977); Michigan, Dep't of Commerce, Ins. Bureau, *Order Transmitting Proposed Rules*, No. 77-R-101 (July 25, 1977).

In addition to the Plans and the state insurance commissioners, federal courts have recognized that the efforts of Blue Shield or Blue Cross Plans to minimize premium rates by containing costs constitute the "business of insurance" within the McCarran-Ferguson Act. For example, in *Doctors, Inc. v. Blue Cross of Greater Phila.*, 431 F. Supp. 5 (E.D. Pa. 1975), *aff'd*, 557 F.2d 1001 (3d Cir. 1976), the district court noted that the state's insurance department had urged the Plan to "exert pressure on the . . . hospitals to limit or do away with unnecessary services in order that insurance rates in Pennsylvania could be lowered." 431 F. Supp. at 10. The Plan, in turn, refused to pay for unnecessary services and to reimburse directly hospitals which performed such services. 431 F. Supp. at 6, 7. When a hospital disgruntled with the Plan's efforts to discourage unnecessary services charged an unlawful conspiracy between the Plan and other hospitals to eliminate competition, the court rebuffed the hospital's efforts to interfere with the cost control program and recognized the state's interest in minimizing insurance rates by lowering health care costs: "[T]he only way to lower insurance rates in Pennsylvania or anywhere would be to lower costs of health care. Therefore, it is clearly within the business of insurance to try to get the health care providers to cut costs." 431 F. Supp. at 10.

Similarly, in *Frankford Hosp. v. Blue Cross of Greater Phila.*, 417 F. Supp. 1104 (E.D. Pa. 1976), *aff'd*, 554 F.2d 1253 (3d Cir.), *cert. denied*, ... U.S. ..... (Oct. 3, 1977), the state authorities insisted that the Plans' contracts with hospitals include quality controls and ceilings on total cost reimbursement. 417 F. Supp. at 1107. A hospital dissatisfied with the cost control terms of the proposed contract with the Plan filed a class action antitrust suit on behalf of all contracting hospitals alleging, among other things, that the Plan had "coerced" the hospitals into signing the agreements in furtherance of

its plan to monopolize the health insurance market. *Id.* at 1108. Rejecting the plaintiff's allegations, the court specifically recognized the state's and the Plan's legitimate interest in minimizing rates by controlling health care costs as a part of the "business of insurance." *Id.* at 1106-09. *See also Travelers Ins. Co. v. Blue Cross of Western Pa.*, 481 F.2d 80, 83 n.9 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973); *St. Bernard Gen. Hosp. v. Hospital Serv. Ass'n of New Orleans, Inc.*, 1978-1 Trade Cas. (CCH) ¶ 61,868 (E.D.La. 1977); *Western Health Care Corp. v. Colorado Hosp. Serv.*, C.A. No. 76-M-760 (D. Colo. Feb. 16, 1977); *Nankin Hosp. v. Michigan Hosp. Serv.*, 361 F.Supp. 1199, 1203 (E.D. Mich. 1973) (certain Plan procedures and standards adopted "for the protection of its subscribers" because of the state's "concern over rising costs of hospital care").

In sum, in sharp contrast to the Fifth Circuit's delineation of the "business of insurance," Blue Shield Plans, state insurance commissioners, and federal courts have regarded cost containment as an essential aspect of the "business of insurance" within the meaning of the McCarran-Ferguson Act. Furthermore, as the next section will document, agreements between the insurer and the provider of services to the insured have been widely recognized by state and federal authorities as effective methods of controlling costs.

B. Agreements Between Insurers And Providers Of Services Are Widely Recognized As An Effective Method Of Controlling Costs.

Agreements between Blue Shield Plans and providers such as participating pharmacies constitute a widely recognized and effective method of minimizing health insurance premiums by controlling the administrative costs and the costs of claims. A review of the cost-saving

elements of the pharmacy agreements is presented below.

Administrative costs are lower when the pharmacy, rather than the subscriber, files the claim, because the claims are more accurate, there are fewer parties involved, and the claims are more easily processed on electronic data processing equipment. *HEW Task Force* at 14. *See also* U.S. Dep't of Health, Education, & Welfare, Health Care Financing Admin., *Research in Health Care Financing* 38 (Spring/Summer, 1977) (results of HEW sponsored pilot study show "significantly" higher administrative costs with patient billing). Claims costs are lower because the participating pharmacy has agreed in advance to accept the acquisition cost plus dispensing fee (less deductible) as full reimbursement from the Plan, which prevents the pharmacy from charging any amount, whatever it may be, to the Plan and to the subscribers.

Furthermore, both administrative and claims costs are reduced by the acquisition cost plus dispensing fee formula because Plans can monitor charges effectively at reasonable administrative cost. With respect to the acquisition cost component, the Plan can compare the amount it is charged for the drug with the pharmacist's cost of acquiring it. With respect to the dispensing fee, the Plan can monitor the amount it pays for the pharmacist's services, including overhead and profit, in an effort to avoid exceeding their average market value without having to compare each claim with each pharmacy's usual charge for the same service. *Third Party Prepaid Prescription Drug Programs: Hearings before the Subcomm. on Environmental Problems Affecting Small Business of the House Select Comm. on Small Business*, 92d Cong., 1st Sess., 292 (1971) (hereinafter "1971 Hearings") (testimony of Waldo A. Stevens).

Federal agencies have explicitly and implicitly recognized the cost effectiveness of the reimbursement formula implemented by the participating pharmacy agreement. A study released by the Council on Wage and Price Stability reported that "contractual agreements with thousands of retail pharmacies to pay the wholesale price for prescription drugs, plus a fixed 'professional fee' for the dispensing service" achieved savings averaging an estimated 15 percent to 20 percent of the retail market price charged to uninsured customers or by nonparticipating pharmacies. Council on Wage & Price Stability, *The Complex Puzzle of Rising Health Care Costs: Can the Private Sector Fit It Together?* 119 (Dec. 1976).

A Task Force of the Department of Health, Education and Welfare also concluded that the acquisition cost plus dispensing fee formula results in reduced drug expenses for those who frequently purchase high-priced prescriptions, lends itself to automatic claims processing and low administrative costs, and tends to result in lower program costs. *HEW Task Force* at 27. Based on the Task Force Study, an HEW Review Committee recommended that this reimbursement formula be embodied in provider contracts for drug benefits under Medicare. U.S. Dep't of Health, Education, & Welfare, Office of the Secretary, *Report of the Secretary's Review Committee of the Task Force on Prescription Drugs* 7-8 (1969).

Indeed, HEW thought so highly of the reimbursement formula that it specifically approved the formula "for reimbursement or payment purposes for any drug used in the programs or activities" which it funds or administers. U.S. Dep't of Health, Education, & Welfare, *Regulations*, 45 C.F.R. § 19.3(a)(2) (1976). Consequently,

almost every state uses this formula to reimburse pharmacists who provide drugs under Medicaid. *Medicaid Fee Freeze Affects Nearly Half the States*, Drug Topics 13 (Aug. 1, 1977). Many states use provider contracts identical in relevant respects to those utilized by the Plans to implement their Medicaid programs. *See, e.g.*, U.S. Dep't of Health, Education, & Welfare, Task Force on Prescription Drugs, *Background Papers: Current American & Foreign Programs* Appendix G (Dec. 1968) (Kentucky agreement). Acquisition cost plus dispensing fee reimbursement is also utilized in the CHAMPUS (Civilian Health and Medical Program for the Uniformed Services) program underwritten by the federal government, in programs offered by other commercial insurers, and in programs required by collective bargaining agreements. Health Ins. Ass'n of Am., *Health Insurance and Prescription Drugs: A Study by D. Jones & J. Follmann, Jr.*, 50 (commercial insurers), 70 (unions), 82 (CHAMPUS) (1971); Pharmaceutical Mfrs. Ass'n, *Pharmaceutical Payment Programs—An Overview: The Financing of Prescription Medicines Through Third Party Programs* 24 (1973).

Besides the federal authorities, state insurance commissioners recognize the cost effectiveness of provider agreements by constantly exercising their statutory authority over the terms of such agreements. For example, former Pennsylvania Insurance Commissioner Herbert Denenberg told a Senate Subcommittee:

> We have been able to generate new cost and quality controls by insisting on incorporation of long overdue reforms in the contracts which Blue Cross plans enter into with member hospitals.
>
> These contracts control over one-half billion dollars in yearly payments to hospitals for services

rendered to subscribers of Pennsylvania Blue Cross plans.

. . .

Blue Cross in Pennsylvania is not satisfied with the traditional cost and quality controls of their hospital contracts. They are experimenting with new cost control reimbursement arrangements.

Commercial Health and Accident Insurance Industry: Hearings before the Subcomm. on Antitrust and Monopoly of the Senate Comm. on the Judiciary, 92d Cong., 2d Sess., Part 1, 388-389 (1972). State insurance commissioners in Illinois and Michigan also have ordered Plans to develop additional cost containment programs by adding certain specified provisions to their contracts with providers of health care services. Illinois, Dep't of Ins., *Order re Proposed Rate Revisions*, Hearing No. 1607 (filed April 8, 1978); Michigan, Dep't of Commerce, Ins. Bureau, *Order Transmitting Proposed Rules*, No. 77-R-101 (July 25, 1977).

Efforts of other state insurance commissioners to control health care costs by regulating the Plans' agreements with providers of health care services are fully documented in several opinions holding that provider agreements constitute the "business of insurance." *See Frankford Hosp. v. Blue Cross of Greater Pa.*, 554 F.2d 1253 (3d Cir.), *cert. denied*, ... U.S. ..... (Oct. 3, 1977); *Travelers Ins. Co. v. Blue Cross of Western Pa.*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973); *St. Bernard Gen. Hosp. v. Hospital Serv. Ass'n of New Orleans, Inc.*, 1978-1 Trade Cas. (CCH) ¶61,868 (E.D. La. 1977); *Western Health Care Corp. v. Colorado Hosp. Serv.*, C.A. No. 76-M-760 (D. Colo. Feb. 16, 1977); *Anderson v. Medical Serv. of D.C.*, 1976-1 Trade Cas. (CCH) ¶60,884 (E.D. Va. 1976), *aff'd*, 551 F.2d 304 (4th Cir. 1977).

C. Agreements Between An Insurer And The Provider Of Health Care Services Constitute The "Business Of Insurance."

This Court has recognized that the "business of insurance" is not confined to the insurer-insured relationship. *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969). The Fifth Circuit agreed with this Court's previous observation that the "business of insurance" includes "other activities which relate . . . to [the insurers'] status as reliable insurers." 556 F.2d at 1380. The Fifth Circuit failed to understand, however, that the pharmacy agreements vitally affect both the insured and the reliability of the insurer, not only because they minimize premium rates by controlling costs, but also because they enable the insured and insurer to predict accurately the costs of benefits to be provided under the program. Thus, they unquestionably constitute the "business of insurance" within the meaning of the McCarran-Ferguson Act.

The cost plus dispensing fee reimbursement formula is the *only* practicable means of predicting the cost of a program of providing benefits for eight million claims for reimbursement for prescription drugs purchased by several million subscribers from thousands of pharmacies, and of offering the program at reasonable cost. *1971 Hearings* at 290-292 (testimony of Waldo A. Stevens). Thus, the pharmacy agreements were used by the Michigan Plan to implement the drug program negotiated by the UAW and automobile companies in order to satisfy the demands of both the companies and the union for a program which would provide meaningful benefits at a reasonable cost. Goldberg & Loren at 423-24. As a Blue Cross official told the House Subcommittee, predictability was also important:

> Well, our customer, in this case many of the industries, would have to know the cost of providing

> this benefit to its employees would be reasonable, that you could reasonably predict the cost of this benefit to their employees. In other words, General Motors or the Ford Motor Co. would not like it if we set up a drug program that they negotiated and purchased and if after a year we had to increase the premium rates 50 percent. What they like is reasonable predictability of cost built within the program, and unions especially are after that control and predictability feature.

1971 Hearings at 291 (testimony of Waldo A. Stevens).

If the Plans could not deliver promised drug benefits at the rate charged, customers would view them as unreliable. The increased costs of programs without effective cost controls is one of the major reasons employers cancel health insurance contracts. Rose, *Meeting the Challenge of Rising Hospital Costs*, J. of Health Politics, Policy & L. 146 (Summer 1976). The Fifth Circuit could not have considered the effect of unpredictable and uncontrolled costs on the relationship between the insurer and the insured when it suggested that the way to avoid the impact of its decision on rates would be for the Plan simply to raise them. 556 F.2d at 1382.

Contrary to the Fifth Circuit's suggestion in its attempt to distinguish the *Travelers* case, 556 F.2d at 1382, the fact that the specific terms of a particular pharmacy agreement are not expressly *mandated* by the state insurance commissioner does not remove the agreement from the "business of insurance." A similar argument advanced by the Federal Trade Commission was rejected by this Court in *FTC v. National Cas. Co.*, 357 U.S. 560 (1958):

> Each State in question has enacted prohibitory legislation. . . . Petitioner does not argue that the statutory provisions here under review were mere pretense. Rather, it urges that a general prohibition . . . is too 'inchoate' to be 'regulation' until that prohibition has been crystallized into 'administrative elaboration of these standards and application in individual cases.' However, assuming there is some difference in the McCarran-Ferguson Act between 'legislation' and 'regulation,' nothing in the language of that Act or its legislative history supports the distinctions drawn by petitioner. So far as we can determine from the records and arguments in these cases, the proviso in Section 2(b) has been satisfied.

357 U.S. at 564. Thus, regulation which generally prohibits, proscribes or permits conduct is sufficient under the McCarran-Ferguson Act.

The lower courts have uniformly followed this principle. For example, in *Ohio AFL-CIO v. Insurance Rating Bd.*, 451 F.2d 1178 (6th Cir. 1971), *cert. denied*, 409 U.S. 917 (1972), the court noted that although a number of cases considered arguments that the exemption was unavailable because of a lack of regulation, ". . . in no case has it been decided that the exemption was inapplicable because of a failure of state regulation." 451 F.2d at 1183. The court held that:

> [T]here is nothing in the language of the McCarran Act or in its legislative history to support the thesis that the Act does not apply when the state's scheme of regulation has not been effectively enforced.

451 F.2d at 1184. *See also, Seasongood v. K & K Ins. Agency*, 548 F.2d 729, 734 (8th Cir. 1977); *Commander Leasing Co. v. Transamerica Title Ins. Co.*, 477 F.2d 77, 84 (10th Cir. 1973); *Meicler v. Aetna Cas. & Sur. Co.*, 372 F. Supp. 509, 513 (S.D. Tex. 1974), *aff'd*, 506 F.2d 732 (5th Cir. 1975).

This general principle has been applied to cases involving health insurance programs. Although some

states specifically authorize regulation of provider contracts, such detailed regulation is not required to invoke the protection of the Act. In *Western Health Care Corp. v. Colorado Hosp. Serv.*, CA No. 76 M 760 (D. Colo. Feb. 16, 1977), the court held that a contract between the Plan and the hospital was within the scope of the exemption where the Plan was regulated by a Nonprofit Hospital Act which gave the insurance commissioner "general authority to investigate and regulate" the Plan. No. 76 M 760, slip opin. at 5. In *St. Bernard Gen. Hosp. Inc. v. Hospital Serv. Ass'n of New Orleans*, 1978-1 Trade Cas. (CCH) ¶61,868 (E.D. La. 1977), the court held that provider agreements were part of the "business of insurance" and exempt from the federal antitrust laws where the underlying insurance contracts had been approved by the Commissioner of Insurance even though the provider agreements had not been specifically approved. ¶61,868 at 73,636.

Regardless of the precise contours of a state's particular regulatory system, this Court has acknowledged the intent of Congress to exempt all such systems from the federal antitrust laws to the extent they regulate the "business of insurance":

> Moreover, in taking this action Congress must have had full knowledge of the nationwide existence of state systems of regulation and taxation; of the fact that they differ greatly in the scope and character of the regulations imposed and of the taxes enacted; and of the further fact that many, if not all, include features which, to some extent, have not been applied generally to other interstate business. Congress could not have been unacquainted with these facts and its purpose was evidently to throw the whole weight of its power behind the state systems, notwithstanding these variations.

Prudential Ins. Co. v. Benjamin, 328 U.S. 408, 430 (1946). Aware of the variety of state regulation of the insurance business, Congress did not intend to require a particular kind of regulation to exempt insurance under the McCarran-Ferguson Act.

D. Application Of The Federal Antitrust Laws To Insurer-Provider Agreements Would Impair State Regulation Of Insurance.

The Fifth Circuit's decision subjects one aspect of the insurance business, the insurer-provider agreements, to the federal antitrust laws while exempting another integrally related aspect of the insurance business, the insurer-insured relationship, from the same laws. Thus, the health insurer's business would become subject to two potentially conflicting sets of rules, *i.e.*, those embodied in the state insurance commissioner's regulatory policies versus those in the federal antitrust laws. Such a conflict would not only interfere with state regulation of the insurer-provider and insurer-insured relationships, but would also impair the health insurer's compliance with state regulation of the two relationships.

The Fifth Circuit's decision would effectively deprive the state of its ability to develop and apply a combination of regulatory systens which in its view will best provide reasonable cost health insurance for its citizens. The McCarran-Ferguson Act, by designating the states as the primary insurance regulators in the absence of any federal law which "specifically relates to the business of insurance," left this policy decision to the states. Accordingly, some states decided to pursue the objective of reasonable cost health insurance entirely through special insurance statutes administered by their insurance commissioners without applying their antitrust laws to the insurance industry. *See, e.g.*, Ill. Rev. Stat. 1975, ch. 38, § 60-5(4); Hawaii Rev. Stat. § 480-11(b) (1968); Md. Code Ann. C.L. § 11-203(4) (1975); N.J.

Stat. Ann. § 56:9-5(b)(4) (Supp. 1977). Other states chose to enact special unfair competition statutes applicable to the insurance industry which permit the insurance commissioner to decide on a case-by-case basis whether the application of antitrust principles to a particular insurance activity will advance the objective of reasonable cost health insurance for its citizens. *See, e.g., FTC v. National Cas. Co.*, 357 U.S. 562, 564 n. 6 (1958); *Addrisi v. Equitable Life Ins. Soc'y of United States*, 503 F.2d 725, 728 (9th Cir. 1974), *cert. denied*, 420 U.S. 929 (1975); *Commander Leasing Co. v. Transamerica Title Ins. Co.*, 477 F.2d 77, 83 (10th Cir. 1973). Still other states decided that wholesale application of their antitrust laws to all insurance activities will best achieve the objective of reasonable cost health insurance. *See, e.g., Steingart v. Equitable Life Assur. Soc'y of United States*, 366 F.Supp. 790, 793-794 (S.D.N.Y. 1973); *California League of Indep. Ins. Prod'rs v. Aetna Cas. & Sur. Co.*, 175 F.Supp. 857, 860 (N.D. Cal. 1959).

Under the Fifth Circuit's decision, a state insurance commissioner could not authorize its health insurers to enter into certain arrangements with providers which, though containing costs, might conceivably raise questions under the federal antitrust laws even though the state found that this was the best way to provide reasonable cost, comprehensive health insurance for its citizens. For example, in *Travelers Ins. Co. v. Blue Cross of Western Pa.*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973), the court noted that, in order to reduce costs, the insurance commissioner had approved a provider reimbursement contract with the Plan which had been "negotiated jointly" by competing hospitals. 481 F.2d at 84.

Moreover, the Fifth Circuit's decision would necessarily affect the states' ability to regulate the insurer-

insured relationship, a relationship which this Court has previously characterized as the very "core" of the "business of insurance." *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969). The Fifth Circuit concedes that some states may have to raise premium rates to accommodate the increase in costs resulting from its decision. 556 F.2d at 1382.

In addition, the Fifth Circuit's decision would place the insurer in the untenable position of attempting to comply with two potentially conflicting regulatory policies. Many insurers would find that their cost containment efforts were to be guided by the federal antitrust laws, while their rates and benefits would have to be tailored to other, potentially inconsistent, rules promulgated by the states.

For example, notwithstanding the Fifth Circuit's decision, a state might still decide that its interest in providing reasonable cost health insurance to its citizens is best served by the insurance commissioner's regulation of the insurer-insured relationship. Accordingly, the state insurance commissioner might direct an insurer to charge a rate or provide a particularly comprehensive scope of benefits which would not be economically feasible without vigorous cost containment efforts which might conceivably raise questions under the federal antitrust laws. If the federal antitrust laws prohibited the insurer from making these efforts, the insurer might have to resign itself to a continuous loss of money and eventual financial insolvency, unless and until the insurance commissioner permitted an increase in rates in order to accommodate increases in costs.

II.

THE PHARMACY AGREEMENTS PROMOTE COMPETITION, IN ACCORDANCE WITH THE FEDERAL ANTITRUST LAWS.

The Fifth Circuit's construction of the "business of insurance" appeared to be influenced by its view of the merits of the case with regard to the antitrust issues. In particular, the Fifth Circuit stated that the pharmacy agreements "do not require Blue Shield to fix prices or to produce other anticompetitive effects in the pharmaceutical industry." 556 F.2d at 1381. Thus, the court implied that the "business of insurance" does not include violations of the federal antitrust laws. Such reasoning would render the entire McCarran-Ferguson Act meaningless by exempting from the federal antitrust laws only activities which do not violate the federal antitrust laws. *Cf. Dexter v. Equitable Life Ass. Soc'y of United States*, 527 F.2d 233, 236 (2d Cir. 1975).

Even if the legality of the agreements under the federal antitrust laws had any legitimate bearing on the scope of the phrase "business of insurance,"* the pharmacy agreements unquestionably withstand the scrutiny of the federal antitrust laws. Indeed, the Plans designed the reimbursement formula in the pharmacy agreements to allow the interplay of market forces in the retail drug industry to determine the cost of

* Of course, to the extent that such agreements constitute boycott, coercion or intimidation, Section 1013(b) of the McCarran-Ferguson Act would not exempt them from the federal antitrust laws. 15 U.S.C. § 1013(b). The Fifth Circuit, however, did not discuss the applicability, if any, of the "boycott exception."

The court below suggests that if the McCarran-Ferguson Act were inapplicable the federal antitrust laws would be fully applicable. Any such conclusion appears to be erroneous for a number of different reasons: *e.g.*, under principles articulated by this Court in *Parker v. Brown*, 317 U.S. 341 (1943), and related cases, the federal antitrust laws might not apply if state regulatory authorities mandated, approved, encouraged or otherwise participated in the challenged activities.

prescriptions. The Department of Justice has repeatedly taken the position that such agreements do not violate the federal antitrust laws.

A. Blue Shield's Pharmacy Agreements Were Designed To Permit The Free Play Of Market Forces To Determine The Cost Of Each Prescription.

As discussed in the introductory section of this memorandum, the total reimbursement to the participating pharmacy consists of the acquisition cost of the drug, plus the dispensing fee, minus the deductible, if any. The acquisition cost is determined by market forces in the wholesale drug industry and is not affected by the pharmacy agreements. The deductible, though initially determined through negotiation between the insurer and the insured, can subsequently be discounted by individual participating pharmacies. The dispensing fee is merely a unilateral offer from the Plan to each pharmacy to provide services for a specified price. Since the plaintiffs complain bitterly about the inadequacy of the dispensing fee (Respondents' Brief in Opposition to Certiorari at 5-13), a description of its history, background and operation may be useful.

Several years before the drug programs were initiated, two courts had ruled that concerted action by pharmacists which had the intent and effect of fixing retail prescription drug prices violated Section 1 of the Sherman Act. *Northern California Pharm. Ass'n v. United States*, 306 F.2d 379 (9th Cir.), *cert. denied*, 371 U.S. 862 (1962); *United States v. Utah Pharm. Ass'n*, 201 F. Supp. 29 (D. Utah 1962). In light of these decisions, the Plans decided to determine the amount of the dispensing fees unilaterally and to let the market accept or reject the offers. *1971 Hearings* at 298 (testimony of Waldo A. Stevens).

In 1969, Lewis Bernstein, Chief of the Special Litigation Section of the Antitrust Division, agreed with the Plans' interpretation of these cases. He told retail pharmacists that they could not bargain collectively with insurers over the amount of the dispensing fee or make a collective decision about whether to accept or reject the offers without violating the antitrust laws under the principles of *Northern California Pharmaceutical* and *Utah Pharmaceutical*. However, as he went on to explain, these prohibitions did not leave the druggists without bargaining power. Mr. Bernstein said:

> Additionally, the interest of the several plans in preserving existing channels of drug distribution compel them to carefully consider adequate compensation for the druggist. The individual druggist's reaction to the fee offered must be considered in developing the plan. Here is why. Most plans will be developed as a result of demands upon employers by their employees to include prepaid prescription drugs in the health benefit plans which they furnish. In turn, the employers will pass their requirements along to their insurance carriers. The carriers must develop plans that will satisfy the employees or the employer will seek another carrier that will. To satisfy the employee the plan must afford them the ability to get their prescriptions filled readily in their neighborhood drug stores. No plan will have the member's support if it obligates him to travel distances to get his prescriptions filled in emergencies. Consequently, the insurance carrier is compelled to offer a dispensing fee that it believes will be acceptable to the individual druggist. If it does not, it runs the risk that sufficient number of individual pharmacists will reject the plan. This will induce the employer to seek another insurance carrier to satisfy the demands of the union.

Bernstein, *Antitrust Aspects of Prepaid Prescription Plans* 10, 11 (address to Annual Convention of National Ass'n of Retail Druggists, Las Vegas, Nev., Oct. 15, 1969) (mimeo).

Mr. Bernstein's analysis is borne out by an examination of the development of the UAW program. In 1967, the Michigan Plan became obligated to implement the prescription drug program agreed to in the UAW-auto industry labor contract. To do this effectively, it had to get a large number of pharmacists to agree to participate. *1973 Hearings* at 103-04 (testimony of Donald G. Puscas). Because the program would account for only a small part of the existing retail drug sales, the Plan had to offer a dispensing fee which equaled the market value of the pharmacists' services. However, the Michigan program was the first major undertaking of its kind and there was no separate market price for such a dispensing fee.

The Plan therefore undertook an extensive study of current prices and published data on retail pharmacy operations and costs in Michigan. *Id.* at 104. Based on this study, the Michigan Plan found that the average gross margin on retail prescription drugs, including expenses for salaries and overhead and return on investment, was approximately 46 percent. Applying this figure to the average price of a prescription drug sale yielded an average "dispensing fee" of $1.80 per prescription. *Id.* Because the study used actual data, these calculations took account of the cost of providing the customary level of service (including the cost of record-keeping, delivery, emergency and consulting services) for most pharmacies. *Id.* at 105. To account for inflation between the time of the study and July 1969 when the program was to begin, as well as to establish a price which would be valid for a reasonable time thereafter, the Plan decided to offer an initial fee of $2.00 to pharmacists in the State of Michigan. *Id.* at 104. The

satisfactory initial response to this offer indicated that the Michigan Plan had in fact offered a good deal. *Id.* at 109.

Reviewing these developments in 1973, Donald G. Puscas, Executive Vice President of the Michigan Plan, testified before a House Subcommittee that the Plan's objective had been to offer a dispensing fee which reflected existing and customary charges, and satisfied the variable needs of many types and sizes of businesses. *Id.* at 105. The Plan had no intention to affect the market price; rather, the Plan's goal was to see that, on average, pharmacists would neither gain nor suffer by participating. The objective was to have the market continue to behave as if no program existed. *Id.* at 208, 213. At that time, Bruce B. Wilson, Deputy Assistant Attorney General of the Antitrust Division, and Barry Grossman, Chief of the Evaluation Section, again explained, as Mr. Bernstein had earlier, that the constraints of the market in which the programs operated inevitably required insurers to do exactly what the Michigan Plan had accomplished. *Id.* at 61.

Nevertheless, the plaintiffs in the instant lawsuit attempt to support their assertion that they are "coerced" into accepting inadequate compensation from the Plan by comparing the dispensing fee with drug acquisition costs which range from $8 to $80. Respondents' Brief in Opposition to Certiorari at 6. This is misleading. According to one survey based on pharmacies in New York, Vermont, Massachusetts and Pennsylvania, the average cost of a prescription purchased at a retail pharmacy in 1976 was $5.22, and more than 70 percent of retail prescriptions cost less than $6.00 in that year.*

* The 1976 average prescription price nationwide was about $5.66. Eli Lilly & Co., *Lilly Digest: A Survey of Community Pharmacy Operations for 1976* 26 (1977).

De Nuzzo, *Annual Prescription Survey by the Albany College of Pharmacy*, Med. Marketing & Media 32, 40 (April 1977). Dispensing fees offered by Blue Shield and Blue Cross Plans in 1976 ranged from $1.85 to $3.11 in various states, with only four Plans offering less than $2.00. Blue Cross Ass'n-Blue Shield Ass'n, *Out-of-Hospital Prescription Drug Data for 1976* 20-27 (July 1977) (internal report). Based on these figures, one may conclude that the dispensing fee normally represents at least a 50 percent markup over the acquisition cost of drugs used for a typical prescription. Plans have periodically adjusted their dispensing fees to continue to attract a sufficient number of participating pharmacies. *See, e.g., Drug Topics* 28 (Sept. 1, 1977); *Am. Druggist* 25 (Sept. 1977).

Dispensing fees offered to participating pharmacists by the states under the Medicaid program are lower than those offered by the Plans. In 1976 they ranged from $1.24 to $2.86 with more than ten states paying less than $2.00. *Medicaid Fee Freeze Affects Nearly Half the States*, Drug Topics 13 (Aug. 1, 1977). Medicaid purchases account for about 8 percent of total retail drug sales, Gibson & Mueller, *National Health Expenditures Fiscal Year 1976*, 40 Soc. Sec. Bull. 3 at 9, 11 (April 1977), while Plan programs account for about two percent. *Id.* at 9; Mueller, *Private Health Insurance in 1975: Coverage, Enrollment, and Financial Experience*, 40 Soc. Sec. Bull. 3 at 7, 14 (June 1977). Accordingly, the economic woes of the independent pharmacists who are plaintiffs in this case can scarcely be attributed to "unfair" and "coercive" fees offered by the Plans. In fact, a recent study attributed the independents' economic problems to their refusal to participate in Medicaid programs and to offer prices as attractive as "chain" stores. Feierman & Kushner, *Chain Rx Departments Outpace Independents*, Am. Druggist 47, 50 (May 1977).

B. The Department Of Justice Has Followed The Development Of Prepaid Prescription Drug Programs, Repeatedly Stating That They Do Not Violate The Federal Antitrust Laws.

The Antitrust Division has regularly scrutinized prepaid drug insurance programs and has never alleged that the pharmacy agreements violate the antitrust laws. In the latter part of 1967, the Department of Justice, following its Business Review Procedure, reviewed a prescription drug program proposed by the Kansas Physicians' Service (Kansas Blue Shield) which contained a similar reimbursement provision and provided for participating pharmacy agreements like the ones challenged in this case. (Appendix D hereto.) The Department of Justice advised the Kansas Plan in January 1968 that it did not intend "to initiate any proceedings under the federal antitrust laws to prevent placing the plan into effect." (Appendix E hereto.) In October 1968, the Department of Justice issued a similar letter to another prescription drug program which offered to reimburse contracting pharmacists for the acquisition costs plus a dispensing fee. Like the Plan programs, the dispensing fee in that program was to be calculated unilaterally by the intermediary, and no concerted price action by pharmacists was contemplated. (Appendix F hereto.)

In addition to the foregoing formal review procedures, subsequent statements of Department of Justice officials indicate that they have monitored the development of prepaid drug programs and have found the pharmacy agreements to be completely lawful under the antitrust laws. In 1971 a Department of Justice spokesman told a House Subcommittee that the pharmacy agreements did not violate the antitrust laws as long as pharmacists did not participate as a group in negotiating the amount of

the dispensing fee. *1971 Hearings* at 230-31 (statement of Bruce B. Wilson).

Thereafter, at the request of some retail pharmacists, the House Subcommittee on Environmental Problems Affecting Small Business requested an extensive study of the operation of the prescription drug programs. This was done by an inter-agency committee formed by the Department of Health, Education, and Welfare in which the Department of Justice participated. *1973 Hearings* at 52. After the committee had completed its work, the Department of Justice again stated that "it is our . . . policy not to challenge programs where the carrier makes a unilateral offer to the pharmacies." *Id.* at 56.

CONCLUSION

BSA urges this Court to reverse the decision of the Fifth Circuit. The court below misunderstood the realities of today's health insurance market and the operation of the Plans' prepaid prescription drug programs. Numerous state and federal regulatory and judicial authorities have declared that cost containment, because of its integral relation to rates and premiums, is a fundamental aspect of the "business of insurance." The Department of Health, Education, and Welfare and various other government agencies have recognized the proven ability of these pharmacy agreements (and the reimbursement formula contained therein) to help control the escalating cost of health insurance.

The Fifth Circuit held, in essence, that cost containment has no place in the "business of insurance." The decision below would subject insurers to the vagaries of

potentially conflicting state and federal regulatory policies and would undermine the states' role as the primary regulators of the "business of insurance." This result is particularly unwarranted because the challenged drug program clearly does not violate the federal antitrust laws. Indeed, the public record shows that the program was specifically designed to allow the free interplay of market forces to determine the cost of prescriptions.

In sum, BSA respectfully submits that the decision of the Fifth Circuit should be reversed because cost containment efforts, such as the pharmacy agreements in this case, are a fundamental part of the "business of insurance" and are entitled to the full protection of the McCarran-Ferguson Act.

Respectfully submitted,

JAMES W. RANKIN
ROGER G. WILSON
MILDRED B. LEVY
KIRKLAND & ELLIS
200 East Randolph Drive
Chicago, Illinois 60601
(312) 861-2000

Attorneys for
Blue Shield Association

Dated: May 13, 1978

APPENDIX

APPENDIX A

(*Letterhead Of*)

LAW OFFICES OF

COX, SMITH, SMITH, HALE & GUENTHER
INCORPORATED
SAN ANTONIO, TEXAS 78205

April 10, 1978

Mr. Michael Rodak, Jr.
Clerk, Supreme Court of the
United States
1 First Street, N.E.
Washington, D.C. 20543

Re: 77,952, *Group Life and Health Insurance Company, et al. v. Royal Drug Company, et al.*

Dear Mr. Rodak:

Petitioners and Respondents hereby consent to the filing of all briefs *amicus curiae* in the above captioned case. Please file this blanket consent in the records of this proceeding.

Sincerely,

/s/ KEITH E. KAISER
For All Petitioners

/s/ JOEL H. PULLEN
For All Respondents

APPENDIX B

BLUE SHIELD PLANS IN THE UNITED STATES

Blue Shield Plans are located throughout the United States. The Plans' principal offices are located in the following cities:

Birmingham, Ala.	Jamestown, N.Y.
Phoenix, Ariz.	New York, N.Y.
Little Rock, Ark.	Rochester, N.Y.
San Francisco, Calif.	Syracuse, N.Y.
Denver, Colo.	Utica, N.Y.
New Haven, Conn.	Durham, N.C.
Wilmington, Del.	Fargo, N.D.
Washington, D.C.	Cleveland, Ohio
Jacksonville, Fla.	Worthington, Ohio
Atlanta, Ga.	Tulsa, Okla.
Columbus, Ga.	Portland, Ore.
Honolulu, Hawaii	Camp Hill, Pa.
Boise, Idaho*	Providence, R.I.
Lewiston, Idaho	Columbia, S.C.
Chicago, Ill.	Sioux Falls, S.D.
Indianapolis, Ind.	Chattanooga, Tenn.
Des Moines, Iowa	Memphis, Tenn.
Topeka, Kansas	Dallas, Texas
Louisville, Ky.	Salt Lake City, Utah
Portland, Maine	Richmond, Va.
Baltimore, Md.	Roanoke, Va.
Boston, Mass.	Bremerton, Wash.
Detroit, Mich.	Seattle, (King), Wash.
St. Paul, Minn.	Seattle (WPS), Wash.
Jackson, Miss.	Spokane, Wash.
Kansas City, Mo.	Tacoma, Wash.
St. Louis, Mo.	Wenatchee, Wash.
Helena, Mont.	Charleston, W. Va.
Omaha, Neb.	Clarksburg, W. Va.
Reno, Nev.	Morgantown, W. Va.
Concord, N.H.	Parkersburg, W. Va.
Newark, N.J.	Wheeling, W. Va.
Albuquerque, N.M.	Madison, Wis.
Albany, N.Y.	Milwaukee, Wis.
Buffalo, N.Y.	Cheyenne, Wyo.

* Became member of Blue Shield Association on March 22, 1978.

APPENDIX C

Prototype Agreements

Out-of-Hospital Prescription Drug Service
Co age Rider (as amended by BCA
Board of Governors on February 10, 1969.)

NOTE: This is a draft of a Rider intended for use with a master group contract to supplement the basic benefits provided thereunder with additional benefits for out-of-hospital prescription drugs. The same terms and conditions may be incorporated in an endorsement to the Subscriber certificate.

Employer Contract No. Rider No. Effective Date

IT IS AGREED that in consideration of the charges stated in the referenced Contract, this Rider is issued to the Employer named hereon and forms a part of said Contract on the above Effective Date.

ARTICLE I—DEFINITIONS

1. "PHARMACY" means any licensed establishment wherein the profession of pharmacy is practiced.

2. "PHYSICIAN" means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is legally licensed, without limitation, to practice medicine and perform surgery. For benefits covered by this Rider, and for no other purposes, Doctors of Dental Surgery (D.D.S.) and Doctors of Dental Medicine (D.M.D.) and Doctors of Surgical Chiropody (D.S.C.) when acting within the scope of their licenses are deemed to be Physicians.

3. "PRESCRIPTION DRUGS" means (a) any medication which by federal or state law may not be dispensed without a prescription and (b) insulin.

4. "PRESCRIPTION ORDER" means the request for medication issued by a physician duly licensed to make such a request in the ordinary course of his professional practice.

5. "PARTICIPATING PROVIDER" means any Pharmacy which or any Physician who regularly dispenses Prescription Drugs and has entered into a Participation Agreement with this Plan or any other Participating Blue Cross or Blue Shield Plan.

6. "NON-PARTICIPATING PROVIDER" means any Pharmacy other than a Participating Provider and any Physician other than a Participating Provider who regularly dispenses Prescription Drugs.

7. "PARTICIPATING PLAN" means any Blue Cross or Blue Shield Plan or other affiliate which has agreed in writing to provide to Subscribers, in whole or in part, benefits described in this Rider.

8. "DEDUCTIBLE" means the amount of $_____($.50, $.75, $1.00 or $1.25—here insert the amount chosen by account) which shall be applied against each Prescription Drug or refill thereof dispensed.

ARTICLE II BENEFITS PROVIDED

1. In addition to the benefits provided under the Contract, benefits shall be available for Prescription Drugs dispensed pursuant to a Prescription Order for the out-of-hospital use of the Subscriber or his Dependent covered under this Rider so long as the same is in effect, subject to the applicable deductible, if any, as follows:

(a) From a Participating Provider: The Participating Provider will furnish such Prescription Drugs and will not make any charge or collect from the Subscriber any amount which exceeds the deductible amount set forth in this Rider.

(b) From a Non-Participating Provider of this Plan or any other Participating Plan: the Subscriber shall be entitled to reimbursement from the Plan in

an amount not to exceed 75% of the Provider's usual and ordinary charges as determined by the Plan, after the deductible, if any, has been applied.

(c) From a Non-Participating Provider in a Non-Participating Plan area: the Subscriber shall be entitled to 100% of such Provider's usual and ordinary charges as determined by the Plan, less the deductible, if any.

2. The benefits under this Rider shall be provided to the extent practicable in the form of service, and payment therefor by or on behalf of the Plan shall constitute a complete discharge of the obligations of the Plan to the extent of the service rendered in accordance with the terms and conditions of this Rider. The Plan shall indemnify the Subscriber directly for that part of the benefits which are not provided in the form of service in accordance with the terms and conditions hereof and reserves the right to indemnify the Subscriber directly for all benefits provided herein.

ARTICLE III—LIMITATIONS

1. A Participating or Non-Participating Provider need not dispense a Prescription Order which for any reason, in his professional judgment, should not be filled.

2. The quantity of Prescription Drugs dispensed pursuant to an original Prescription Order shall be limited to a supply of thirty-four (34) consecutive days, except that _____
(this blank to be completed by naming certain drugs or classes of drugs from those listed in the attachment, as determined by the national account with the Control Plan, including the present combination of natural thyroid products and nitroglycerine as now provided in Article III, paragraph 2 of the June 14, 1967 approved rider) may be distributed in quantities up to 100 unit doses for each prescription.

3. Refills shall be dispensed only pursuant to a Prescription Order and shall be subject to the same

limitations as contained in Paragraph 2 above. If the number of refills is not specified in the Prescription Order, refills will not be provided beyond one year from the original prescription date.

4. This Rider carries no conversion privilege.

ARTICLE IV—EXCLUSIONS

In addition to the exclusions in the Contract, no benefits shall be provided for:

1. Other than Prescription Drugs such as contraceptive devices, therapeutic devices, artificial appliances, hypodermic needles, syringes or similar devices.

2. Administering or injecting Prescription Drugs.

3. Any contraceptive medication, even if such medication is a Prescription Drug.

ARTICLE V—CONDITIONS UNDER WHICH SERVICE SHALL BE RENDERED

1. The Subscriber's identification card shall be presented to the Participating Provider when the Subscriber or Dependent applies for benefits under this Rider.

2. As a condition precedent to the approval of claims hereunder, each Subscriber and Dependent authorizes and directs and [*sic*] Provider who furnished benefits hereunder to make available to the Plan information relating to all Prescription Orders, copies thereof and other records as needed by the Plan. The Plan shall in every case hold such information and records as confidential.

3. The Plan shall not be liable for any claim or demand for injury or damage arising out of or in connection with the manufacturing, compounding, dispensing, or use of any Prescription Drug whether or not covered under this Rider.

Classes of Drugs which may be obtained as paid benefits in quantities up to 100 unit doses.

Antiarthritic Drugs
Anticoagulants
Anticonvulsants
Antidiabetics
Antifungal
Antihistamine
Cardiac Drugs
Diaretics
Hormones
Hypotensive
Anticholinergic and Parasympatholytic
Nitroglycerine
Vitamins Bearing Legend
Thyroid Preparations
Urinary and Intestinal Anti-Infectives
Phenobarbital
Contraceptives (where applicable)

N.B. Intent to keep with current practice.
In many cases: 100 = 34-day supply.

Specimen Participating Provider Agreement

6/14/67

NOTE: This is a draft of a prototype agreement with a Participating Pharmacy. A similar agreement will be required where a physician or dentist is the participating provider of services. It is contemplated that the benefits to which a Subscriber is entitled will be communicated to the pharmacy (or other provider) by furnishing a copy of the Subscriber certificate or instruction booklet.

THIS AGREEMENT made this ____ day of _____, 19___, by and between ____(Plan)____, hereinafter referred to as "Plan," and ____(Pharmacy)____, hereinafter referred to as "Pharmacy," doing business as a pharmacy under pharmacy permit No. _____ and located at _____.

1. The Pharmacy represents that it has a current valid permit issued by the ____(name of state)____ State Board of Pharmacy and that it is conducted as a (Note: If a partnership, the partners' names will be enumerated; if a sole proprietorship, the owner's name will be stated; and if a corporation a statement that the signatory is duly authorized to sign and will provide a copy of the articles of incorporation and by-laws).

2. The Plan agrees that it will furnish to all eligible Subscribers an identification card which the Subscriber must present to the Pharmacist in order to obtain services. The Pharmacy agrees to provide to a properly identified Subscriber the prescription drugs, required by the prescription orders which are covered benefits under the Subscriber's Out-of-Hospital Prescription Drug contract with this Plan or any other Participating Blue Cross or Blue Shield Plan or affiliate. The Pharmacy may not charge or collect from the Subscriber any amount which exceeds the deductible amount set forth in such contract.

3. The Pharmacist need not dispense a prescription order which for any reason, in his professional judgment, should not be filled. The Plan shall have the sole right, subject to the above, to determine the individuals eligible for benefits to be furnished by the Pharmacist and for which the Pharmacist is to be reimbursed.

4. The Pharmacy agrees to submit promptly to the Plan on forms provided by the Plan such information as the Plan deems necessary to identify the Subscriber and the benefits provided. The Plan agrees, within _____ ( ) days after receiving such form, to pay to the Pharmacy as reasonable compensation for the benefits provided an amount equal to the Pharmacy's acquisition cost of the pharmaceutical product or ingredient plus a dispensing fee of _____ dollars and _____ cents ($_____) for each prescription order filled. Acquisition cost means the actual billed and paid cost of the pharmaceutical product or ingredient to the Pharmacy, reflecting all discounts.

5. The Plan or its duly authorized agents shall have free access during regular business hours upon reasonable notice and demand to such books, records and prescription files of the Pharmacy as may be necessary to perform an audit following generally accepted auditing procedures. It is understood that any information obtained during such audits shall be held confidential by the Plan. Such audits may be made at any time during the term of this Agreement and within one year after its expiration.

6. It is understood and agreed that the Pharmacy may enter into agreements involving other prescription drug programs.

7. The Plan retains the exclusive right to name _____ (here insert Blue Cross and/or Blue Shield) and the _____ symbol, together with any distinctive trademark or service mark that may hereafter be adopted. The Pharmacy agrees not to advertise to the public that it is a participating member of the Plan nor to use the names, symbols, or trademarks of _____ in any manner without the prior written

consent of the Plan. Upon any termination of this Agreement, the Pharmacy will immediately discontinue the use of such names, symbols, or trademarks and forthwith return any signs, placques, insignias, displays, or any other materials indicating its participating member status.

8. The Plan shall not be liable for any claim or demand for injury or damage arising out of or in connection with the manufacturing, compounding, dispensing, or use of any prescription drug whether or not covered under this Agreement and/or the Subscribers Out-of-Hospital Prescription Drug Rider, and the Pharmacy agrees to hold the Plan harmless against any and all such claims or demands.

9. This Agreement may be terminated by either party on _____ ( ) days prior written notice. However, during said _____ ( ) day period, this Agreement and the obligations hereunder shall remain in full force and effect. The Plan, notwithstanding the above, reserves the right to cancel this Agreement at any time by written notice for cause, whereupon the Pharmacy's membership shall terminate forthwith. This right of immediate cancellation shall not in any way affect the Plan's other rights enumerated under this Agreement. This Agreement shall remain in effect notwithstanding any notice of change or adjustment in the Dispensing Fee set forth in Paragraph 4 herein, unless the Pharmacy gives written notice of its election to terminate.

10. No person, agent, or officer of the Plan is authorized to alter or vary the terms hereof, nor to make any representation or inducements relative thereto other than those specifically set forth herein. This Agreement represents the complete and total understanding of the parties.

Signed and sealed this ____ day of ____, 19 ___.

Pharmacy Name (Seal)	(Plan)
by _____	by _____
Title	Title

APPENDIX D

Application by Kansas Physicians' Service, a nonprofit corporation, commonly known as Kansas Blue Shield—Business Review Procedure—proposed prepaid prescription drug prepayment plan, August 30, 1967:

(Letterhead Of)

GOODELL, CASEY, BRIMAN,
RICE & COGSWELL

August 30, 1967

Assistant Attorney General's Office
Antitrust Division
Department of Justice
Washington, D. C. 20530

Gentlemen:

In re: Application by Kansas Physicians' Service, a non-profit corporation, commonly known as Kansas Blue Shield—Business Review Procedure—proposed prepaid prescription drug prepayment plan

We are the attorneys for Kansas Physicians' Service, commonly known as Kansas Blue Shield. Please consider this letter as the application of our client for a review of a proposed Blue Shield prescription drug prepayment program, under your Business Review Procedure for an advance clearance as to whether or not your Department will waive its right to institute criminal proceedings under the antitrust laws.

I am enclosing, herewith, the following documents:

(1) Proposed Agreement to be issued by Kansas Blue Shield to its subscribers providing prescription medications coverage and designated as "Full Pay Plan."

(2) Proposed Agreement to be issued by Kansas Blue Shield to its subscribers providing prescription medications coverage and designated as "Shared Pay Plan."

(3) Proposed Agreement to be executed by Kansas Blue Shield and individual Pharmacists who elect to become a participating pharmacy under the prepaid drug plan.

The above documents are all operative documents proposed for issuance by Blue Shield to implement the plan. Kansas Physicians' Service, commonly known as Kansas Blue Shield, is a non-profit corporation, incorporated under the provisions of the non-profit Medical Service Corporation Act of Kansas. I am enclosing, herewith, a copy of the non-profit Medical Service Corporations Act of Kansas for your review and assistance in determining the matter. I am also enclosing one copy of an Opinion issued by the Attorney General of Kansas, dated April 21, 1965, holding that Kansas Physicians' Service has the authority to issue Dental coverage plans under the provisions of K.S.A. 40-1902, which reads in part as follows:

> "Such corporations heretofore or hereafter organized may also provide service or indemnity for *other health services* but not to exceed reasonable and customary charges that a subscriber may incur for these services." (emphasis added)

Kansas Blue Shield proposes to issue the prepaid drug plan under the authority of the above quoted section which allows the issuance of such plan "for other health services."

In general, the proposed drug prepayment plan will be issued to citizens of the State of Kansas who elect to pay the premium determined by Kansas Blue Cross-Blue Shield to be necessary to allow this coverage. A subscriber may elect to have any prescription filled at any pharmacy of his choice. In the event that the subscriber has coverage under the "Full Pay Plan," eligible prescriptions will be filled by either a participating or a non-participating Pharmacist selected by the subscriber. In the event that the Pharmacist is a participating Pharmacist, the subscriber will provide proof of coverage under this agreement, to the Pharmacist. The participating Pharmacist will then, under the terms of his agreement with Kansas Blue Shield, receive from Kansas Blue Shield an amount equal to the Pharmacist's actual acquisition cost of the prescription medication (as defined in the policy) and a dispensing fee of $2.00. In the event that the subscriber elects to have the prescription filled at a non-participating pharmacy, the subscriber will pay the amount direct to the Pharmacist and then make a claim to Blue Shield. Kansas Blue Shield will provide an indemnity of an amount not to exceed 75% of the usual and customary charge of the Pharmacy, or 75% of the amount a participating pharmacy would have charged for the same prescription, whichever is the lesser.

The procedure for the proposed "Shared Pay Plan" in general is identical except for the amount to be paid by Kansas Blue Shield. In the "Shared Pay Plan" the participating pharmacist will charge the subscriber 50% and Blue Shield will pay to the participating pharmacist the remaining 50% of the charge for the prescription. Under the "Shared Pay Plan," the subscriber will pay the full charge of the non-participating pharmacist, and the subscriber will be entitled to an indemnity of an amount not to exceed 50% of 75% of the usual and customary charges of the non-participating pharmacist, or 50% of 75% of the amount paid to a participating pharmacy for the same prescription, whichever is lesser.

In general, the above summarizes the proposed plan of business conduct maintained by Kansas Physicians' Service. In the event that you need any additional information or documents, please advise and the same will be furnished immediately.

If possible, we hope that your office can review the proposed plan and issue an opinion under the Business Review Procedure at the earliest possible time, hopefully by Sep-

tember 15, 1967. If it is not possible to secure an opinion by that date, we would appreciate receiving your best estimate as to the time required.

Very truly yours,
/s/ Gerald L. Goodell
Of Goodell, Casey, Briman, Rice & Cogswell

GLG :mh
Encs.
cc Blue Cross-Blue Shield

FULL PAY PLAN

Kansas Blue Shield

PRESCRIPTION MEDICATIONS RIDER

Out-Of-Hospital Only

ARTICLE I. GENERAL PROVISIONS

A. This is a Rider to a Contract or Certificate issued by Kansas Physicians' Service, Topeka, Kansas, a non-profit corporation known as Kansas Blue Shield. The appropriate terms and provisions of the Kansas Blue Shield Contract or Certificate to which this Rider is attached apply except as otherwise specified in this Rider.

B. This Rider is issued for attachment to the Kansas Blue Shield Contract or Certificate and becomes effective for the Subscriber on the Benefit Date shown on the Identification Card.

ARTICLE II. DEFINITIONS

The following definitions are added to Article I, Definitions, of the Contract or Certificate:

A. *Prescription Order* is the request for medication issued by a duly licensed physician, dentist, or podiatrist in the authorized course of his professional practice.

B. *Prescription Charges* shall represent the acquisition cost of the drugs or medication actually used in preparation of the prescription pursuant to a Prescription Order plus a dispensing fee.

C. *Acquisition Cost* shall mean the usual and customary pricing basis but in no instance greater than the—

1. Blue Book Cost, by Manufacturer.
2. Blue Book Cost, by Manufacturer, shall be determined as follows:
   a. Readymade Capsules, Pills, Tablets, and similar Substance—Cost per 100 units.
   b. Readymade Liquids—Cost of 16 ozs.
   c. Readymade ointments and powders dispensed from bulk package—Cost per pound.
   d. Originals—Ear Drops, Eye Drops, Nose Drops, Sprays, and Ointments in tube or jar —Cost of Package.
   e. Injectables—Cost of Ampules—Cost of Vials.
   f. Compounded Prescription—Cost of Ingredient plus 50¢.

D. *Dispensing Fee* means the fixed amount established by the Plan which is paid to the Participating Pharmacy over and above the Acquisition Cost for each Prescription Order or refill dispensed.

E. *Prescription Medications* means drugs or biologicals dispensed for human use pursuant to a Prescription Order which are legend drugs and are thus required, under the Federal Food and Cosmetic Act, to bear the legend: "Caution, Federal law prohibits dispensing without prescription." Excluded are contraceptive medications unless specifically included as an option.

F. *Participating Pharmacy* shall mean any licensed pharmacy which has entered into an agreement with the Plan to provide the pharmaceutical services listed in this Rider.

G. *Non-Participating Provider* shall mean any licensed pharmacy in Kansas which or licensed physician who, has not entered into an agreement with the Plan.

H. *Participating Contract* shall mean the agreement entered into between the Plan and the Participating Pharmacy which shall set forth their respective rights and obligations.

I. *Physician* shall mean a Doctor of Medicine or a Doctor of Osteopathy duly licensed to practice medicine or osteopathy at the time and place the service is provided.

ARTICLE III. RELATIONSHIP BETWEEN SUBSCRIBER AND PARTICIPATING PHARMACY

A. The Agreement between Kansas Blue Shield and the Participating Pharmacy may be terminated by either Kansas Blue Shield or the Participating Pharmacy at any time upon thirty (30) days' prior written notice to the other.

B. It is understood that the Pharmacy need not dispense a Prescription Order for any reason which, in the pharmacist's professional judgment, should not be honored.

ARTICLE IV. ELIGIBLE SERVICES

Charges for Prescription Medications, except for the exclusions indicated in Article V of this Rider, dispensed for use by the Subscriber or any of his eligible Dependents when the Prescription Order is requested by a licensed physician, dentist, or podiatrist in the authorized course of his professional practice.

A. Limitations:

(1) Only drugs and biologicals which are legend drugs, and are thus required, under the Federal Food and Cosmetic Act, to bear the legend: "Caution, Federal law prohibits dispensing without prescription."

(2) Refills will be covered up to one year from the date of the Prescription Order.

(3) The quantity of Prescription Drugs dispensed pursuant to an original Prescription Order shall be limited to a supply of thirty-four (34) consecutive days, except that Prescription Orders for medications whose acquisition cost is not greater than $1.00 shall be limited to 100 unit doses for each prescription.

ARTICLE V. EXCLUSIONS

A. The following exclusions apply to the benefits of this Rider in addition to the exclusions of the basic Contract or Certificate to which this Rider is attached:

1. Prescriptions written by any practitioner other than a duly licensed physician, dentist, or podiatrist in the authorized course of his professional practice.
2. The purchase of products other than drugs or biologicals, such as contraceptive or therapeutic devices, artificial appliances, etc.
3. Administration or injection of Prescription Medications.
4. Non-legend, patent, or proprietary drugs.
5. Contraceptive medications unless specifically included as an option.

B. No duplicating payment will be made under this Rider for Prescription Medications which are provided under any other Rider to the Kansas Blue Shield Contract or Certificate to which this Rider is attached.

ARTICLE VI. BENEFITS PROVIDED

A. Benefits will be available for Subscribers' expenses for Prescription Medications when dispensed by a Participating Pharmacy or by a Non-Participating Provider pursuant to a Prescription Order for the out-of-hospital use by the Subscriber or his Dependent covered under this Rider so long as the same is in effect.

At the discretion of Blue Shield, certain devices may be included if related to the use of the prescribed medication.

B. Participating Pharmacy: A Participating Pharmacy will provide the Prescription Order to the Subscriber and will make no charge to the Subscriber.

C. Non-Participating Provider: The Subscriber shall be entitled to an indemnity of an amount not to exceed 75 percent of the Provider's usual and customary charge, or 75 percent of the amount paid to a Participating Pharmacy for the same prescription, whichever is lesser.

ARTICLE VII. PRODUCT LIABILITY

Blue Shield shall not be responsible for any claims arising out of or through the manufacturing, compounding, dispensing, and use of any Prescription Medications whether covered under this Agreement or not.

ARTICLE VIII. CONDITIONS

The Subscriber's Blue Shield Identification Card shall be presented to the Participating Pharmacy when the Subscriber or Dependent applies for benefits under this Rider. The Subscriber authorizes and directs any Pharmacy or other Provider to furnish and make available to Blue Shield any Prescription Order copies for which benefits shall have been claimed on behalf of himself and enrolled dependents.

KANSAS PHYSICIANS' SERVICE
Topeka, Kansas

Attest:
Secretary

President

Form No. .....
7-14-67 rev.

SHARED PAY PLAN

(First 4 Pages same as Full Pay Plan)

ARTICLE V. EXCLUSIONS (continued)

A. 3. Administration or injection of Prescription Medications.
4. Non-legend, patent, or proprietary drugs.
5. Contraceptive medications unless specifically included as an option.

B. No duplicating payment will be made under this Rider for Prescription Medications which are provided under any other Rider to the Kansas Blue Shield Contract or Certificate to which this Rider is attached.

ARTICLE VI. BENEFITS PROVIDED

A. Benefits will be available for Subscribers' expenses for Prescription Medications when dispensed by a Participating Pharmacy or by a Non-Participating Provider pursuant to a Prescription Order for the out-of-hospital use by the Subscriber or his Dependent covered under this Rider so long as the same is in effect, subject to the shared payment agreement in paragraph D of this section. At the discretion of Blue Shield, certain devices may be included if related to the use of the prescribed medication.

B. Participating Pharmacy: A Participating Pharmacy will provide the Prescription Order to the Subscriber and will make no charge to the Subscriber other than the shared payment amount of fifty percent (50%). Blue Shield will pay to the Participating Pharmacy the remaining fifty percent (50%) of covered Prescription Charges.

C. Non-Participating Provider: The Subscriber shall be entitled to an indemnity of an amount not to exceed fifty percent (50%) of 75 percent of the Provider's usual and customary charges, or fifty percent (50%)

of 75 percent of the amount paid to a Participating Pharmacy for the same prescription, whichever is lesser.

D. The Subscriber is responsible for the payment of fifty percent (50%) of the covered Prescription Medication Charges.

ARTICLE VII. PRODUCT LIABILITY

Blue Shield shall not be responsible for any claims arising out of or through the manufacturing, compounding, dispensing, and use of any Prescription Medications whether covered under this Agreement or not.

ARTICLE VIII. CONDITIONS

The Subscriber's Blue Shield Identification Card shall be presented to the Participating Pharmacy when the Subscriber or Dependent applies for benefits under this Rider. The Subscriber authorizes and directs any Pharmacy or other Provider to furnish and make available to Blue Shield any Prescription Order copies for which benefits shall have been claimed on behalf of himself and enrolled dependents.

KANSAS PHYSICIANS' SERVICE
Topeka, Kansas

Attest:
Secretary

President

Form No. .....
7-14-67 rev.

Proposed

BLUE SHIELD CONTRACT WITH
PARTICIPATING PHARMACIES

SECTION I. DEFINITIONS

A. *Plan* means Kansas Physicians' Service, hereinafter known as Kansas Blue Shield.

B. *Subscriber* is the person, or any of his eligible dependents, with whom the Plan has entered into a contract to provide benefits.

C. *Dependent* means the spouse of the Subscriber and each eligible dependent child.

D. *Contract Holder* means any individual or organization which has agreed, on behalf of the Subscriber, to remit to the Plan the rates payable under the Subscriber's agreement.

E. *Prescription Order* is the request for medication issued by a duly licensed physician, dentist, or podiatrist in the authorized course of his professional practice.

F. *Prescription Charges* shall represent the acquisition cost of the drugs or medication actually used in preparation of the prescription pursuant to a Prescription Order plus a dispensing fee.

G. *Acquisition Cost* shall mean the usual and customary pricing basis but in no instance greater than the—

1. Blue Book Cost, by Manufacturer.
2. Blue Book Cost, by Manufacturer, shall be determined as follows:
   a. Readymade Capsules, Pills, Tablets, and similar Substance—Cost per 100 units.
   b. Readymade Liquids—Cost of 16 ozs.
   c. Readymade Ointments and Powders dispensed from Bulk Package—Cost per pound.
   d. Originals—Ear Drops, Eye Drops, Nose Drops, Sprays, and Ointments in tube or jar —Cost of Package.
   e. Injectables—Cost of Ampules—Cost of Vials.
   f. Compounded Prescription—Cost of Ingredient plus 50¢.

H. *Dispensing Fee* means the fixed amount established by the Plan which is paid to the Participating Pharmacy over and above the Acquisition Cost for each Prescription Order or refill dispensed.

I. *Prescription Medications* means drugs or biologicals dispensed for human use pursuant to a Prescription Order which are legend drugs, and are thus required, under the Federal Food and Cosmetic Act, to bear the legend: "Caution, Federal law prohibits dispensing without prescription." Excluded are contraceptive medications unless specifically included as an option. At the discretion of Blue Shield, certain devices may be included if related to the use of the prescribed medication.

J. *Participating Pharmacy* shall mean any licensed pharmacy which has entered into an agreement with the Plan to provide the pharmaceutical services listed in the Subscriber's contract.

K. *Participating Contract* shall mean the agreement entered into between the Plan and the Participating Pharmacy which shall set forth their respective rights and obligations.

SECTION II. GENERAL AGREEMENT OF PARTIES

THIS AGREEMENT, made this ..... day of ....., 19...., by and between Kansas Physicians' Service (hereinafter called 'Blue Shield') and ..... (hereinafter called 'Pharmacy'), doing business as a pharmacy with Pharmacy Permit No. ..... located at .... has a current valid permit issued by the Kansas State Board of Pharmacy. The Pharmacy is conducted as a (partnership), (sole proprietorship), (corporation).

Blue Shield agrees that it will furnish to all eligible Subscribers an Identification Card which the Subscriber must present to the pharmacist before he is required to render services. The Pharmacy agrees to provide to such properly identified Subscribers the Prescription Medications required by their Prescription Orders, which are covered under the Subscriber's Prescription Medication Rider or Contract. Prescription Orders must be

made by a duly licensed physician, dentist, or podiatrist in the authorized course of his practice. The pharmacist need not dispense a Prescription Order which for any reason, in his professional judgment, should not be honored. Prescription Medications covered under the Rider or Contract include only those drugs or biologicals dispensed for human use pursuant to a Prescription Order which are legend drugs, and are thus required, under the Federal Food and Cosmetic Act, to bear the legend: "Caution, Federal law prohibits dispensing without prescription." Excluded are contraceptive medications unless specifically included as an option. Refills shall not be covered after one (1) year from the date of the Prescription Order. The quantity of Prescription Drugs dispensed pursuant to an original Prescription Order shall be limited to a supply of thirty-four (34) consecutive days, except that Prescription Orders for medication whose acquisition cost is not greater than $1.00 shall be limited to 100 unit doses for each prescription.

Blue Shield will have the sole right, subject to the above, to determine the individuals eligible for service by the pharmacist for which he is to be reimbursed. The Pharmacy agrees to furnish Blue Shield, on forms to be provided by Blue Shield, a true and correct statement for the Prescription Medications dispensed, including the patient's name and identifying number, the acquisition cost, the total Prescription Charge, and the amount (if any) payable by the Subscriber pursuant to this Contract, and other pertinent information in accordance with the Participating Pharmacy Manual.

Blue Shield agrees to pay as reasonable compensation for the Pharmacy's services an amount equal to the Pharmacy's usual and customary pricing basis but in no instance greater than the Blue Book Cost, and a Dispensing Fee of Two Dollars ($2.00). The Pharmacy agrees to accept in full for its services the payment described in this paragraph without any charge to the Sub-

scriber except for those Subscribers who select the shared payment plan. In this instance, the Pharmacy shall credit the Subscriber in accordance with the plan selected.

The Pharmacy agrees to allow Blue Shield or its duly authorized agent free access to and to furnish such agent during regular business hours, upon demand, such books, records, and prescription files as may be necessary to perform an audit to insure that Acquisition Costs are as reported on claims. It is understood that all information so furnished shall be held as confidential by Blue Shield. Such audits may be made at any time during the term of this Contract or within one year thereafter.

It is understood that the Pharmacy may enter into agreements with any other prepaid prescription drug program and/or commercial insurance company, whether profit or non-profit.

Blue Shield retains the exclusive right to the name 'Blue Shield' and the Blue Shield symbol together with any distinctive trademark and/or service mark that may hereafter be adopted. The Pharmacy agrees not to advertise to the public that it is a Participating Pharmacy nor to use the names, symbols, or trademarks, or 'Blue Shield' in any advertising without the prior written consent of Blue Shield. Upon termination of this Contract, the Pharmacy will immediately discontinue the use of such names, symbols, or trademarks and immediately return any signs, plaques, insignias, displays, or any other advertising material indicating its participating status.

Blue Shield shall not be responsible for any claims arising out of or through the manufacturing, compounding, dispensing, and use of any Prescription Drugs whether covered under this Contract or not, and the Pharmacy agrees to hold Blue Shield harmless against any such claim or demand.

This Contract may be amended at any time by attaching hereto an amendment properly executed by all parties to this Contract.

This Contract may be terminated by either party on thirty (30) days written notice. However, during the said thirty (30) day period, both parties agree that this Contract and its obligations hereunder shall remain in full force and effect.

Blue Shield, notwithstanding the above, reserves the right to cancel this Contract at any time for any breach of this Contract by the Pharmacy and its participation shall terminate forthwith. This right to immediate cancellation by Blue Shield does not in any way effect its other rights enumerated under this Agreement.

No person, agent, or officer of Blue Shield is authorized to alter or vary the terms hereof, nor to make any representation or inducements relative hereto other than those specifically set forth herein. This Contract represents the complete and total agreement of the parties.

Signed and sealed this ..... day of ....., 19.....

..... KANSAS PHYSICIANS' SERVICE

By ..... By .....

(Title) (Title)

(seal) (seal)

APPENDIX E

Department of Justice Clearance, January 15, 1968:

(Letterhead Of)

DEPARTMENT OF JUSTICE

January 15, 1968

Gerald L. Goodell, Esquire
Goodell, Casey, Briman,
Rice & Cogswell
Columbian Building
Topeka, Kansas 66603

Dear Mr. Goodell:

This responds to your letter request of August 30, 1967 for a clearance by the Department of Justice under the Business Review Procedure for a proposed prepaid prescription drug plan to be offered by the Kansas Physicians Service, a non-profit corporation commonly known as Kansas Blue Shield. A copy of a summary of the Department's Business Review Procedure is attached.

Your August 30, 1967 letter outlining the nature of the proposed plan, your supplemental letter of September 27, 1967, and the attached operative documents which are to be used in carrying out the proposed plan have been reviewed.

We understand from your representations that the prices to be paid participating pharmacists, including the amount of the dispensing fee, have been unilaterally determined by Blue Shield, and that future changes in prices will also be determined unilaterally. In this connection, we understand that the prepaid prescription drug plan does not contemplate inviting any concerted action among the pharmacists, or within any pharmaceutical association, pursuant to which pharmacists would agree upon or jointly act in determining whether to join the plan or in determining

the schedule of drug prices or the amount of the dispensing fees to be paid by Blue Shield.

We also understand that the 25% differential in fees paid non-member pharmacists reflects a reasonable assessment of the additional administrative expenses in processing such claims.

This is to advise that on the basis of the information submitted, the Department does not propose to initiate any proceedings under the federal antitrust laws to prevent placing the plan into effect in the manner outlined in your letters. In view of the novelty of the proposal, we reserve the right to assess its actual operation and to take appropriate action in the event experience under the plan or the manner in which the plan is implemented indicates a violation of the antitrust laws.

Sincerely yours,
/s/ Donald F. Turner
Assistant Attorney General
Antitrust Division

Attachment

APPENDIX F

**Department of Justice Clearance,
October, 1968 (Paid Prescriptions)**

October 1, 1968

James Robert Nielsen, Esq.
General Counsel
Paid Prescriptions
Post Office Drawer 5335
Carmel, California 93921

Dear Mr. Nielsen:

This responds to your request of September 18, 1968 under the Business Review Procedure for an expression by the Department of Justice of its enforcement intentions concerning the proposed course of business conduct to be followed by Paid Prescriptions, Inc. We have previously furnished you with a copy of the text of the Business Review Procedure of the Department.

In your letters of September 16 and 18, 1968 you have described the manner in which Paid Prescriptions has been restructured and the changes that are proposed to be made in the terms of the Participating Pharmacy Agreements which establish the drug prices and professional fees to be paid to participating pharmacists.

We understand from your representations that the prices for drugs and professional fees to be paid to pharmacists with which Paid Prescriptions proposes to contract have been unilaterally determined by Paid Prescriptions and that any changes in such drug prices or professional fees will also be determined unilaterally. We further understand that Paid Prescriptions does not contemplate inviting or acquiescing in any concerted action among pharmacists or any pharmaceutical

associations pursuant to which pharmacists will jointly act in determining whether to enter into the proposed contract with Paid Prescriptions or in determining the drug prices or professional fees to be charged for prescriptions furnished to persons who are beneficial members of Paid Prescriptions, Inc.

This is to advise you that on the basis of the information submitted the Department does not propose to initiate any criminal proceedings under the federal antitrust laws if the proposed revisions in the prepaid prescription program are carried out in the manner described in your letters and the accompanying documents.

Sincerely yours,

/s/ EDWIN M. ZIMMERMAN
Assistant Attorney General
Antitrust Division

Supreme Court, U. S.
FILED
APR 26 1978
MICHAEL RODAK, JR., CLER

In the Supreme Court
OF THE
United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, et al.,
Petitioners,

vs.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, et al.,
Respondents.

On A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF OF CALIFORNIA DENTAL SERVICE AND DELTA DENTAL PLANS ASSOCIATION AS AMICI CURIAE

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In the Supreme Court
OF THE
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OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, et al.,
Petitioners,

vs.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, et al.,
Respondents.

On A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF OF CALIFORNIA DENTAL SERVICE AND DELTA DENTAL PLANS ASSOCIATION AS AMICI CURIAE

This brief is filed for California Dental Service and Delta Dental Plans Association with the written consent of all parties to this proceeding pursuant to Rule 42 of the Court.

NATURE OF THE INTEREST OF AMICI CURIAE

California Dental Service is a California nonprofit corporation which undertakes to furnish or pay for dental service for its subscribers in return for premiums paid by them or on their behalf. It provides dental care coverage for approximately 4.5 million individuals, largely in California. It is the defendant in *Manasen v. California Dental Services,* 424 F.Supp. 657 (N.D.Cal. 1976) currently on appeal to the Court of Appeals for the Ninth Circuit (Court of Appeals docket nos. 77-1751 and 77-1752). The *Manasen* case is discussed in detail by the Court of Appeals for the Fifth Circuit in its decision below. As such discussion indicates, the two cases present closely related issues, and the decision in the case at bar probably will be dispositive of many of these issues.

Delta Dental Plans Association is an Illinois nonprofit corporation which includes in its membership 43 nonprofit dental service corporations similar to California Dental Service, organized in 42 states and the District of Columbia.

California Dental Service and the other members of Delta Dental Plans Association are the analogues in the field of dental care and insurance to Petitioner Blue Shield of Texas in the field of medical care and insurance. Although practices and the requirements of state law vary considerably from state to state, typically these nonprofit dental service corporations function by means of contractual arrangements with dentists which are similar to the contracts between Blue Shield and pharmacies at issue in the case at bar.

Amici curiae are therefore vitally interested in the central issue now before the Court: Whether the Sherman Act applies to agreements between health insuring organizations and health care providers.

SUMMARY OF ARGUMENT

The purpose of the McCarran-Ferguson Act is broadly to give support to state systems for regulating and taxing the business of insurance. In construing the scope of the "business of insurance", for which the Act affords limited exemption from the federal antitrust laws, due consideration must be given to the extent and purpose of state regulations. State insurance laws and regulations often require health insurers to limit by contract the price charged by providers of health care. Federal health insurance legislation also encourages, and in some instances mandates, controls on the costs of health care. The Court of Appeals' narrow view that the insurer-provider relationship is outside of the "business of insurance" ignores these significant state and federal policies.

ARGUMENT

I. THE PURPOSE OF THE McCARRAN-FERGUSON ACT.

The Court has had several occasions to consider the underlying purpose of the McCarran-Ferguson Act (59 Stat. 33 (1945), 15 U.S.C. §§ 1011-1015). In the first case to consider the Act, *Prudential Insurance Co. v. Benjamin,* 328 U.S. 408, 429 (1946), the Court

held: "Congress's purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance."

Later, in *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 458-60 (1969), the Court considered in depth the history and purpose of the Act, and particularly the meaning of the phrase "business of insurance" in § 2(b) [15 U.S.C. § 1012(b)]. The Court then found that, while the Congressional debates and Committee reports shed little light on the meaning of the words "business of insurance", the meaning is relatively clear in the context of the problems Congress was dealing with. After reviewing the history of the Act, the Court concluded:

Given this history, the language of the statute takes on a different coloration. The statute did not purport to make the States supreme in regulating all the activities of insurance *companies;* its language refers not to the persons or companies who are subject to state regulation, but to laws "regulating the *business* of insurance." Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the "business of insurance" does the statute apply. Certainly the fixing of rates is part of this business; that is what South-Eastern Underwriters was all about. The selling and advertising of policies, FTC v National Casualty Co., 357 US 560, 2 L Ed 1540, 78 S Ct 1260 (1958), and the licensing of companies and their agents, cf. Robertson v. California, 328 US 440, 90 L Ed 1366, 66 S Ct 1160 (1946), are also within the scope of the statute. Congress was concerned with the type of state regulation

that centers around the contract of insurance, the transaction which Paul v Virginia held was not "commerce." The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the "business of insurance." Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."

We will show in this brief that the activity involved here—health insurers'[1] contracts with the providers

[1]The District Court observed in *Frankford Hospital v. Blue Cross of Greater Philadelphia*, 417 F.Supp. 1104, 1106 (D.C.E.D. Pa., 1976), aff'd 554 F.2d 1253 (3rd Cir., 1977), cert. den., 46 U.S.L.W. 3218: "Blue Cross is not an insurer in the classic sense of that term. In its contracts with subscribers it agrees to furnish them needed health care services in return for premiums paid by them, or on their behalf (e.g., by employers). In order to carry out these obligations Blue Cross contracts with eligible hospitals. In a typical situation, a subscriber goes to a member hospital, presents his or her Blue Cross card, and receives health care services and the hospital sends the bill directly to Blue Cross. On the other hand, a patient insured under a traditional, private health insurance policy is billed for the services he receives and is entitled to receive cash indemnification by his insurer in the amount determined by his particular policy." In this brief we nevertheless refer to health service organizations such as Blue Cross, as well as "traditional" carriers, as "health insurers", as both are generally regulated by state insurance laws and are engaged in the "underwriting of risks, the one earmark of insurance as it has commonly been conceived of in popular understanding and usage." *Securities and Exchange Commission v. Variable Annuity Life Insurance Company*, 359 U.S. 65, 73 (1959).

of care—is intimately and inextricably connected to the fixing of rates and to the status of the health insurer as a reliable insurer. To hold that this activity is outside the definition of the term "business of insurance", as used in the McCarran-Ferguson Act, is to deny the basic purpose of the Act, at least as it applies to health insurance.

II. THE REQUIREMENT THAT HEALTH INSURERS CONTRACT WITH PROVIDERS OF HEALTH CARE IS AN INTEGRAL PART OF STATE REGULATION OF HEALTH INSURERS FOR THE PURPOSE OF FIXING OF RATES AND ASSURING THEIR STATUS AS RELIABLE INSURERS.

Most states include special provisions in their insurance laws authorizing and regulating health service organizations. While it is difficult to generalize about the laws of 50 states, state laws regulating health service organizations commonly require that the health insurance organization enter into contracts with providers of services (hospitals, physicians, dentists, pharmacists, etc.) and that these contracts specify the fees or compensation which the providers are entitled to receive, or a formula for determining such compensation.[2]

[2]Alaska Stat. §§ 21.87.140, .150, .190(a) (1966); Colo. Rev. Stat. §§ 10-16-107, -130 (1973); Del. Code Ann. Title 18 § 6304(b)(3) (1975); Fla. Stat. Ann. §§ 641.04(2)(c), (3)(b) (1972), repealed by Laws 1976, ch. 76-168, § 3(3)(2), eff. July 1, 1982 (Supp. 1976); Ga. Code Ann. §§ 56-1705, -1711, -1705a, -1717a, -1718a(3), -1802(7), -1810, -1822, -1823(3) (1977); Idaho Code §§ 41-3403(5), -3408(3), (4), -3415, -3415A, -3416, -3419, -3421(1)(b) (1977); Ill. Ann. Stat. ch. 32 §§ 555 (Supp. 1978), 579, 667, 690.32, 691.31 (1970); Kan. Stat. Ann. §§ 40-1803, -1903, -19b04 (Supp. 1977); Mass. Gen. Laws Ann. ch. 176A § 5, ch. 176B § 4, ch. 176E § 4, ch. 176F § 4 (Supp. 1977), ch. 176C § 5 (1958); Mich. Compiled Laws Ann. §§ 550.503 (Supp. 1977), 550.506 (1967); Minn. Stat. Ann. §§ 62C.02 subd. 8, 62C.16 (Supp. 1977); N.J. Stat. Ann. §§ 17:48-7, :48C-2(d), :48C-15 (Supp. 1977), 17:48A-8 (1963); N.Y. Insurance Law § 254 (McKinney Supp. 1977); Ohio Rev. Code Ann. § 1739.051 (Supp. 1976); Gen. Laws of R.I. §§ 27-19-14 (Supp. 1977), 27-19-7 (1969); Code of Va. Ann. §§ 32-195.23, -195.38 (1973); W.Va. Code Ann. § 33-24-7 (1975).

These state laws regulating the business of insurance and requiring that health insurers contract with providers of health services have at least two purposes. First, the contracts with providers limit the health insurers' liability, thus tending to assure their status as reliable insurers. Second, since the amount which health insurers are obligated to pay to providers of health services obviously is the major cost factor in health insurance, contracts which limit provider charges have a direct and major effect on the rates charged for health insurance.

The first function of provider contracts, assuring the health service organization's status as a reliable insurer, derives from the fact that most health service organizations were formed as nonprofit corporations with little or no capital. "Hospitals by and large agreed to provide services for subscribers even if funds were not available to reimburse the institutions. Doctors who contracted with Blue Shield Plans often assented to similar arrangements."[3] These contractual arrangements between the service plans and providers of health services take the place of the re-

[3]Eilers, *Regulation of Blue Cross and Blue Shield Plans* (1963), p. 239.

serves, which are required of traditional insurers to assure their fiscal reliability.'

This function of agreements with providers is clearly recognized by some state statutes. For example, Article 24 of the West Virginia Insurance Law which governs "Hospital Service Corporations, Medical Service Corporations and Dental Service Corporations" requires that the contracts between these corporations and hospitals, physicians, dentists and other health agencies provide "that in case of a deficit in available funds of the corporation, each participating hospital, physician, dentist or other health agency will, on the basis stated in this section, accept a pro rata share of available funds in full settlement of any bill submitted."[5]

The close relationship between premium rates charged to subscribers or policyholders and contractual rates by which health insurers reimburse providers of health services is highlighted by state court decisions in which premium rate increases were examined for compliance with state insurance laws. For example, in *Thaler v. Stern,* 44 Misc.2d 278, 253 N.Y.S.2d 622 (Sup. Ct., Spec. Term, 1964), a subscriber challenged the New York Superintendent of Insurance's approval of a hospital insurer's premium increase. The New York Supreme Court noted:

> . . . . Nor is it any more reasonable for the Superintendent to attempt to pass upon requested

[4]Eilers, *op. cit.*, pp. 135-6; 239-40; A. Somers and H. Somers, *Private Health Insurance*, 46 Calif. Law. Rev. 376, 508, 513 (1958).

[5]W.Va. Code Ann. § 33-24-7(c) (1975); see also statutes of Alaska, Florida, Idaho, Michigan and Minnesota, *supra*, note 2.

> subscriber rate increases without giving any consideration to the adequacy and reasonableness of hospital repayment rates. The relation between the two is elemental. There would be no need for subscriber rate increases were it not for two factors: firstly, there has been a significant increase in utilization of hospital services by AHS subscribers and secondly; and more importantly, there has been a tremendous increase in the reimbursable cost of hospital services. [253 N.Y.S. 2d at 631]

To the same effect, see *Application of Blue Cross,* 34 Ohio Misc. 29, 206 N.E.2d 305 (1972); *In re Rate Filing of Blue Cross Hospital Service,* 214 S.E.2d 339 (W.Va. 1975).

III. CONGRESS HAS SHOWN THAT IT CONSIDERS CONTROLS ON PROVIDER CHARGES TO BE AN ESSENTIAL ELEMENT OF HEALTH INSURANCE.

The federal government is both a major health insurer and a purchaser of health insurance. Congress, in enacting federal health insurance legislation, has required that health providers agree to limit their charges.

In 1965 Congress enacted the Health Insurance for the Aged Act, Pub.L. 89-97, 79 Stat. 286, 42 U.S.C. §§ 1395 *et seq.* Section 102(a) of the Act, 79 Stat. 309, as amended, 42 U.S.C. § 1395u, provides for the use of "carriers" for administration of benefits. It provides that payments for physicians' services shall be on a reasonable charge basis and that the contracts between the government and carriers "shall provide

that the carrier . . . will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will . . . be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of Section 1395(y) of this Title. . . ." [42 U.S.C. § 1395u(b)(3)]

In other words, if a physician wishes to be paid for services provided to a Medicare beneficiary on the basis of an assignment, he must agree to accept as payment in full the "reasonable charges" determined by the carrier contracting with the Secretary of Health, Education and Welfare. If a physician does not agree to an assignment, which limits his charges to the reasonable charge determined by the Secretary and the carrier, he cannot receive payment from the carrier; payment must be made directly to the individual patient (42 U.S.C. § 1395u(b)(5)).

The Senate Finance Committee, commenting on this provision, stated as follows:

> The committee believes that the use by carriers of certain existing mechanisms and procedures will help in the determination of whether a charge is reasonable. . . . And, where service benefit plans, for payment of physicians' services, serve as carriers under the program, the use of the same agreed-upon fee schedules that are employed in their own programs may be helpful in avoiding the possibility of disputes regarding fees. (Senate Report No. 404, 89th Congress, 1st Sess., 44 (1965))

The Senate Finance Committee also noted:

> . . . . It is your committee's intent that the Secretary shall, to the extent possible, enter into contracts with a sufficient number of carriers, selected on a regional or other geographical basis, to permit comparative analysis of their performance. The contracts would have to provide that the carrier would take action to assure that the charges and costs of services for which the supplementary plan may make payment are reasonable [*Ibid.*, at 54]

Similar limitations are imposed by the Health Insurance for the Aged Act on payments to hospitals and other institutional providers of health services (42 U.S.C. §§ 1395f(b), 1395x(u), (v), 1395cc).

An example of the federal government's role as a purchaser of health insurance is the Dependents' Medical Care Act, P.L. 84-569, 70 Stat. 250 (1956), 10 U.S.C. §§ 1071, *et seq.*, Title II of which authorizes the Secretary of Defense to contract for medical care for dependents of military personnel "under

such insurance, medical service, or health plans as he considers appropriate . . ." [10 U.S.C.§ 1079(a)]. The Senate Committee on Armed Services, reporting on the bill which led to this Act, noted:

> . . . . The principal new cost that will result from enactment of the bill is that attributable to the civilian care that would be authorized by title II. These cost estimates are subject to basic assumptions, notable of which are . . . (2) agreement by physicians to some type of maximum fee schedule such as that now in use by the Veterans' Administration. Senate Report No. 1878, 84th Cong., 2nd Session, 9 (1956).

We cite these federal statutes, and their legislative history, to indicate that, when Congress has thrust the federal government into the business of insurance, either as an "insurer" or as a purchaser of insurance, it has also recognized that controls on provider charges are an integral and essential part of that business.

CONCLUSION

Viewed in the light of the state and federal legislative background discussed in this brief, the decision of the Court of Appeals for the Fifth Circuit has serious implications. Both state laws regulating the business of health insurance and federal health insurance legislation recognize insurer-provider agreements concerning charges for health services to be an integral part of health insurance. Congress has relied upon "existing mechanisms" including the "agreed-

upon fee schedules that are employed" by service benefit plans to assure that provider charges paid by the federal government would be reasonable. However, state laws authorizing these same mechanisms are threatened with preemption by the Sherman Act and other federal laws, under the holding of the Court of Appeals.

We submit that the Court of Appeals' conclusion that these mechanisms are not a part of the business of insurance was arrived at without sufficient analysis of their critical role. We therefore join with petitioners in urging that the decision below be reversed.

Respectfully submitted,

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Supreme Court, U. S.
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IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et. al.*,

Petitioners,

vs.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS, and DISCO PRESCRIPTION PHARMACY, *et. al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

AMICUS CURIAE BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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IN THE

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Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

INTEREST OF THE AMICUS CURIAE

The National Association of Insurance Commissioners (NAIC) is an unincorporated association whose membership consists of the principal state insurance regulatory officials charged by law with the responsibility of regulating the business of insurance within each state, the

District of Columbia, Guam, Puerto Rico and the Virgin Islands. The NAIC submits this *amicus curiae* brief with the consent of all parties to this case.

The individual state insurance commissioners who comprise the NAIC and the insurance consuming public, on whose behalf they regulate, have a vital interest in the outcome of this case. Since each state regulates the business of insurance as intended by Congress under the McCarran Act, 15 U.S.C. §§1011-15 (1970), any interpretation of that Act which modifies or diminishes the present scope of state insurance regulation would seriously impair the ability of each member of the NAIC to oversee the business of insurance. Affirmation by this Court of the rationale underlying the Fifth Circuit Court of Appeal's decision would, in the opinion of the NAIC, lead to such an impairment. This result would severely and adversely impact on the ability of the states to foster and sanction appropriate efforts and procedures designed to reduce or at least contain the cost of insurance.

The purpose of this brief is to persuade the Court to frame its decision in a manner which preserves the ability of the states to regulate the business of insurance on behalf of the insurance consuming public. The NAIC will specifically argue that an insurer's efforts designed to reduce or contain the cost of insurance through its impact on the settlement and payment of claims constitutes a part of the "business of insurance." In doing so, the NAIC does not necessarily endorse the details of the health care cost control approach embodied in the Blue Shield plan in the instant case.[1] Furthermore, in this brief the NAIC

[1] For example, the question can be raised as to whether the Blue Shield plan would constitute unfair discrimination under the state's unfair trade practice acts on the basis that all insureds pay the same premium but receive different levels of benefits depending upon the pharmacist they choose. A contrary argument is that unfair discrimination does not exist since each insured has the option to purchase from whomever he chooses. Furthermore, it might be argued that the difference in the amount reimbursed essentially reflects the difference in the cost of processing the claims. However, regardless of the merits of the competing arguments, the issue of unfair discrimination is one for decision under the state insurance laws.

does not address the other McCarran Act issues raised in this case, *i.e.*, whether the state of Texas has regulated the challenged activity in this case and whether the challenged activity falls within the boycott exceptions in the McCarran Act sense.[2] Since the Fifth Circuit Court of Appeals definitively addressed only the "business of insurance" issue, the purpose of the NAIC involvement in the instant case is to urge this Court to construe the "business of insurance" language in a manner that will *not* deter or preclude insurer activities aimed at reducing or containing the cost of insurance, *when appropriately regulated by the states,* by rendering such activities vulnerable to an onslaught of antitrust challenges by those feeling a grievance stemming from lower costs and prices.

ISSUE PRESENTED

Are an insurer's efforts and procedures designed to contain or reduce the cost of insurance through the impact on the settlement and payment of claims a part of the "business of insurance" under the McCarran Act?

[2] It should be noted, however, that the district court held that the challenged activities not only constituted a part of the "business of insurance" but also that the State of Texas regulated the Blue Shield activities and that such activities did not fall within the "boycott" exception to the McCarran Act. Royal Drug Company, Inc. v. Group Life & Health Insurance Co., 415 F.Supp. 343, 351 (W.D. Tex. 1976).

ARGUMENT

I. REASON AND LEGAL PRECEDENT REQUIRE A DETERMINATION THAT AN INSURER'S EFFORTS AND PROCEDURES DESIGNED TO REDUCE OR CONTAIN THE COST OF INSURANCE THROUGH ITS IMPACT ON THE SETTLEMENT AND PAYMENT OF CLAIMS IS A PART OF THE "BUSINESS OF INSURANCE" UNDER THE McCARRAN ACT.

Regardless of the merits of the validity of the Blue Shield prepaid prescription drug insurance program under either a particular state's insurance law or the federal antitrust laws, Blue Shield's reimbursement mechanisms, including the Pharmacy Agreement, are designed to minimize the cost of such insurance, especially through its impact on the settlement and payment of claims.

First, costs are minimized by reducing the expenses of processing claims. Second, prediction of costs in meeting the insurer's obligations is rendered more certain, thereby enabling the establishment of a lower premium. Third, the insurer's allowance of cost plus $2.00 dispensing fee to participating pharmacies minimizes the price which must be paid in the settlement of claims, thereby enabling a lower price for the insurance coverage. Furthermore, to the extent participating pharmacies are a significant competitive force in the market for prescription drugs, the impact of competitive pricing in the overall market is enhanced. This, in turn, further impacts on the aggregate level of claims to be paid by the insurer and the cost of insurance to its insureds. Finally, the nonparticipating pharmacists, in addition to being subject to competitive price pressures stemming from the prices solicited by the insurers, are

also subject to competitive price pressure due to the fact that the insureds purchasing drugs are limited to a 75% reimbursement.

The competitive pressures for reduced prices and/or improved services are not only recognized by the Respondents in this case but also serve as the basic reason for the initiation of this litigation. *Royal Drug Company, Inc. v. Group Life & Health Insurance Co.,* 556 F.2d 1375, 1378-79 (5th Cir. 1977). Thus, regardless of the other merits or demerits of the Blue Shield prescription drug program, it is clear that Blue Shield is trying to reduce or contain the cost of prescription drugs thereby generating lower cost prescription drug insurance than would otherwise be available.

The lower court concluded, however, that "Blue Shield's Pharmacy Agreement is not a part of the business of insurance" under the McCarran Act and consequently not immune from the application of the federal antitrust laws. *Id.* at 1387. This conclusion is based upon the court's interpretation of *SEC v. National Securities, Inc.,* 393 U.S. 453 (1969). The NAIC submits that the lower court's interpretation is erroneous both in terms of reason and as a matter of law.

A. Reason and Existing Legal Precedent Require a Finding That the Challenged Activity is the Business of Insurance Under the McCarran Act.

In *National Securities* this Court said:

> The statute [McCarran Act] did not purport to make the States supreme in regulating all the activities of insurance companies; its language refers not to the persons or companies who are subject to state regulation, but to laws "regulating the business of insur-

ance." Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the "business of insurance" does the statute apply. *Certainly the fixing of rates is part of this business;* that is what South-Eastern Underwriters was all about. The selling and advertising of policies . . . and the licensing of companies and their agents, . . . are also within the scope of the statute. Congress was concerned with the type of state regulation that centers around the contract of insurance . . . . *The relationship between insurer and insured,* the type of policy which could be issued, its reliability, interpretation, and enforcement — *these were the core of the "business of insurance."* Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. *But whatever the exact scope of the statutory term, it is clear where the focus was — it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."* 393 U.S. 453, 459-60 (emphasis added).

Thus, the basic issue of whether the challenged activity is the "business of insurance" depends upon whether such activity involves *"the relationship between the insurance company and the policyholder." See also Travelers Insurance Co. v. Blue Cross,* 481 F.2d 80 (3rd Cir.), *cert. denied,* 414 U.S. 1093 (1973).

The premium which an insured pays for insurance coverage is a fundamental element in the insurer-insured relationship. This Court confirmed such an obvious conclusion when it made clear that state regulation constitutes the regulation of the "business of insurance" when it exercises control over the price of insurance. *National Securities,* 393 U.S. at 460. Since the underlying costs of

a product or a service bear a substantial relationship to the price charged to customers, *Proctor v. State Farm Mutual Automobile Insurance Co.,* 561 F.2d 262, 268-69 n.11 (D.C. Cir. 1977), it seems axiomatic that, subject to some limiting parameters, an insurer's activities designed to reduce or contain the underlying cost of insurance, and thereby enable a lower insurance price, also involve the insurer-insured relationship.[3] In turn, under the standards of the *National Securities* case, such activity constitutes a part of the "business of insurance."

The decision of the lower court in the instant case is in direct conflict with the decisions of other district and circuit courts which support the proposition that an insurer's efforts to reduce or contain the cost of insurance is a part of the "business of insurance." For example, in the leading decision of *Travelers Insurance Co. v. Blue Cross* the plaintiff commercial insurer brought an antitrust action against Blue Cross whose standard contract with hospitals prescribed the amounts and terms pursuant to which Blue Cross would pay for services rendered by the hospital to the Blue Cross subscribers (insureds). This standard contract with the hospital contained limitations as to the types of costs which Blue Cross would have to reimburse as well as a ceiling on costs. As a result, Blue Cross was able to quote correspondingly lower premiums. 481 F.2d at 82. If the hospital refused to enter into such a contract, Blue Cross would reimburse the hospital on a

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[3] Several state court decisions have recognized the close relationship between the premium rates charged to policyholders and the contractual rates at which health insurers reimburse health care providers. In *Thaler v. Stern,* 253 N.Y.S.2d 622, 631 (1964), a New York Supreme Court described the relation between health insurance rates and hospital repayment rates as being "elemental." *See also In re* Rate Filing of Blue Cross Hospital Service, Inc., 214 S.E.2d 339, 344-45 (W. Va. 1975).

per diem basis in an amount insufficient to cover the hospital's cost. The hospital would then have to charge the patient directly for the balance. Blue Cross raised the McCarran Act defense to the plaintiff's antitrust allegations. The Third Circuit Court of Appeals, in applying the standards of the *National Securities* case, concluded that the rates Blue Cross charged to its insureds were so interrelated with the terms in the hospital contracts that the latter constitute part of he "business of insurance" within the meaning of the McCarran Act. *Id.* at 83.

The Fifth Circuit Court of Appeals, in the instant case, attempted to distinguish *Travelers* on the basis that the insurance commissioner in Pennsylvania was exerting pressure on the insurers to reduce health care costs. 556 F.2d at 1382. However, the Third Circuit Court of Appeals in *Travelers* made clear that the hospital reimbursement plan was at the heart of the "business of insurance" in holding that

> In the present case, the district court found that the interrelationship of hospital payments and subscribers' rates was such that Blue Cross' arrangement with hospitals should be considered part of the "business of insurance." This conclusion is a sound construction of the law and is amply supported by the evidence. 481 F.2d at 83.

Thus, it is clear that the existence of state statutory authority and regulatory activity concerning the insurer reimbursement contracts with hospitals, upon which the Fifth Circuit Court of Appeals bases its distinction, relates to the issue whether the state has regulated the "business of insurance," not whether the activity involved constitutes a part of the "business of insurance."[4]

[4] In its opinion in the instant case, the Fifth Circuit Court of Appeals suggests that the instant case is more akin to *Battle v. Liberty National Life Insurance Co.*, 493 F.2d 39 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110 (1975) than to *Travelers*. 556 F.2d at 1383. Such a conclusion is erroneous for at least two reasons. First, *Battle* is clearly distinguishable on the facts. In that case, the defendant insurer issued burial insurance. The insurer contracted with its wholly owned subsidiary to provide the merchandise and service required by the insurance policy. The subsidiary, in turn, contracted with independent funeral homes to perform the obligations under the insurance policy. If the insured went to a participating funeral home, the level of benefits he would have received were significantly greater than if he went to a nonparticipating funeral home.

Several funeral home directors brought an antitrust action against the insurer and its subsidiary. The court in *Battle* clearly distinguished between the facts in *Travelers* and those in *Battle*. As to the former, the court in *Battle* said

> [s]ignificantly, the relationship between the insurance company and the hospitals in *Blue Cross* was a direct contractual relationship. The result of this contract was simply the performance of the insurer's responsibilities owed to the insured under the insurance contract and nothing more.
>
> . . . .
>
> The contractual relationship in the instant [*Battle*] case is not a direct relationship between the insurance company . . . and the funeral directors. . . .
>
> The addition of this [subsidiary company] intermediary is significant because, under the guise and with the assistance of [the . . . subsidiary, the insurer] may have exceeded the business of providing burial insurance and encroached upon the business of providing funeral services. 493 F.2d at 50.

In the instant *Royal Drug* case, Blue Shield contracted directly with the pharmacists. No subsidiary intermediary was involved. Thus, the language in the *Battle* opinion itself leads to the conclusion that *Travelers*, not *Battle*, is more akin to the instant case. *See also* Proctor v. State Farm Mutual Automobile Insuance Co., 561 F.2d 262, 270 (D.C. Cir. 1977).

The *Royal Drug* case is distinguishable from *Battle* on a second basis as well. The Blue Shield contract with the participating pharmacists is clearly designed as a means to reduce the cost of health care and thereby the rates for the prescription drug insurance. The facts in *Battle* apparently did not suggest the same conclusion to the court thereby failing to invoke the insurer-insured relationship criterion under *National Securities*.

The same conclusion reached in *Travelers* was also reached in *Frankford Hospital v. Blue Cross,* 417 F. Supp. 1104, 1109 (E.D. Pa. 1976), *aff'd per curiam,* 554 F.2d 1253 (3rd Cir. 1977) and *Doctors, Inc. v. Blue Cross,* 360 F.Supp. 693 (E.D. Pa. 1973), *aff'd per curiam,* 535 F.2d 1245 (3rd Cir. 1976). *See also Nankin Hospital v. Michigan Hospital Service,* 361 F.Supp. 1199 (E.D. Mich. 1973) in which the court held that "[t]he basic function of Blue Cross of providing pre-paid hospital care is clearly the 'business of insurance' ", *id.* at 1211, and that "the negotiation of contracts with non profit hospitals as regulated by Act 109 constitutes 'acts in the conduct' of such business", *id,* as is the "[e]nforcement of the qualification standards adopted by Blue Cross. . . ." *Id.* The qualification standards deemed to be a part of the "business of insurance" in the *Nankin* case arose from the "concern over rising costs of hospital care. . . ." *Id.* at 1230.

In *Manasen v. California Dental Services,* 424 F.Supp. 657 (N.D. Cal. 1976), the court held that the McCarran Act applied to a nonprofit operation which administered prepaid dental care programs through agreements with various subscriber groups and subscriber purchasers. The subscribers paid periodic premiums to California Dental Service in exchange for future dental services to individuals on whose behalf the premiums were paid. The professional services were performed by either "participating" dentists who agreed to seek payment solely from California Dental Services based upon an approved fee schedule or by "nonparticipating" dentists who did not agree to so limit their charges. Patients obtaining care from participating dentists were entitled to full benefits under the program whereas the other patients received less than full coverage. The plaintiffs alleged that this

program violated the antitrust laws by conspiring to fix dental fees and boycotting those dentists who refused to participate. The court focused on the issue whether a cost containment program, which is conceptually identical to the Blue Shield arrangement in the instant case, constitutes the "business of insurance." The court concluded:

> It is undisputed that *the level of dentists' fees are a major factor in determining policy premiums.* CDS' payment arrangements to service providers are critical elements in CDS' contractual agreements with its subscribers. These arrangements are intimately related to the interpretation and implementation of CDS' policies and to its reliability as an insurer. Accordingly, *the Court finds that the activities challenged in the instant complaint constitute part of the "business of insurance" within the meaning of the McCarran Act. Id.* at 666-67 (emphasis added).

Similarly, *Anderson v. Medical Service,* CCH TRADE REG. REP. (1976-1 Trade Cases) ¶ 60,884, at 68,885 (E. D. Va. 1976), *aff'd,* 551 F.2d 304 (4th Cir. 1977), involved an antitrust action by a physician against a prepaid medical-surgical insurance plan which distinguished between participating and nonparticipating physicians as to reimbursement methods. In upholding the reimbursement methods as part of the "business of insurance" under the McCarran Act, the court said that "[t]he business of insurance refers not only to the relationship between an insurer . . . and its policyholders, it refers also to those other activities which relate so closely thereto that they must be placed in the same class." *Id.* at 68,857. The closely-related activities referred to in this case were the insurers' contracts with health care providers designed in a manner to contain health care costs.

Applicable precedents in other insurance areas support the inclusion of arrangements between insurers and per-

sons other than policyholders which are aimed at reducing or containing the cost of insurance within the term "business of insurance". For example, in *Proctor v. State Farm Mutual Automobile Insurance Co.*, 561 F.2d 262 (D.C. Cir. 1977), four automobile repair shops alleged that the claim adjustment and settlement practices of five automobile insurance companies involved price fixing, coercion and a group boycott. The district court granted summary judgment in favor of the insurers on the basis of the McCarran Act. On appeal, the repair shops asserted that the disputed practices were not a part of the "business of insurance" and the boycott exception to the McCarran Act was applicable.

The repair shops conceded that the challenged activities stemmed solely from the insurers' "desire to slow the rate of increase in the claims payments required to satisfy the companies' contractual obligations to their policyholders," *id.* at 268, and that the "purpose was to minimize increases in the cost of reimbursing damage claims." *Id.* at 271. To achieve these objectives, the repair shops alleged that the insurers agreed, as a basis for settling claims, to reimburse their policyholders according to a common formula involving the prevailing labor rate, a standardized estimate of the amount of labor required and a compulsory discount on parts. Such an alleged agreement was enforced, the repair shops argued, through preferred repair shops who under economic pressure committed themselves to repairing on the insurers' conditions. Policyholders could obtain their repairs from other shops but there was no assurance that they would be reimbursed in full by the insurer if such shops charged a higher price. Thus, the facts are comparable to participating-nonparticipating arrangements in the health care provider cases discussed above.

Commencing its analysis with the standards set down by this Court in the *National Securities* case, the Circuit Court of the District of Columbia concluded that

> the alleged horizontal agreement to pay insureds' claims on the basis of the prevailing labor rate, as well as appellees' supposed adherence to a common formula to compute damage estimates, *fits within the "core" of the "business of insurance."* The essence of the automobile insurance contract is the insurance company's agreement, in return for a premium, to make payments to or on behalf of the policyholder for losses arising out of the ownership, maintenance, or use of an automobile. *The determination by the insurance company of the amount to be paid in discharge of this contractual obligation is at the heart of the relationship between insurer and insured,* and is directly connected with the reliability, interpretation, and enforcement of the insurance contract. 561 F.2d at 267 (emphasis added).

As to the alleged arrangement with the preferred body repair shops the court rejected the argument that the arrangement was the business of automobile repair rather than the business of insurance:

> In the circumstances of this case, we conclude that the alleged agreements with preferred shops and the asserted group boycott of non-cooperative shops *are connected closely enough to the contractual relationships* between the appellees and their policyholders, and with the reliability, interpretation, and enforcement of those contracts, to qualify as the business of insurance [emphasis added].
>
> . . . .
>
> *Notwithstanding their effect on non-policyholders, the activities unquestionably grow out of and are tied to, the* claims adjustment and settlement process [emphasis added].
>
> . . . .

Of central significance in this entire context is the close relationship between the cost of reimbursing damage claims, on the one hand, and the insurance rates charged by appellees, on the other. Any doubt as to whether these activities should be deemed to fall within the business of insurance is ponderably eased by that economic reality. *Indeed, in a case involving similar activities, the Third Circuit concluded that a substantial impact on rates, in and of itself, was sufficient to satisfy the statutory standard,* [emphasis added] based on the language in *National Securities* to the effect that the business of insurance includes "other activities of insurance companies [which] relate so closely to their status as reliable insurers."

. . . .

For the purposes of this case, it is sufficient to say that the vital impact on appellees' rates, found by the District Court, provides additional support for our conclusion that the disputed practices are a part of the of the business of insurance. Id. at 268-70 (citations omitted) (emphasis added).

Although the circuit court noted that it did not have to "decide whether a substantial effect on rates, standing alone, is enough to qualify an activity as the business of insurance," *id.* at 269, the language in the opinion comes close to doing so. Certainly, the court gives such impact on rates substantial weight. Furthermore, the court made clear that when an insurer's activity relates to both its "claims adjustment and settlement process" and to the "cost of reimbursing claims" which, in turn, is closely related to the "insurance rates charged," such activity clearly constitutes a part of the "business of insurance."

Although the insurer-health care provider cases cited and discussed *supra* may suggest that whenever an insurer undertakes efforts to reduce the cost of insurance, such

activity constitutes a part of the "business of insurance," the NAIC does not maintain that there are no activities beyond the parameters of the McCarran Act exemption. Insurance company activities that may impact on the cost of insurance which are undertaken from other than the perspective of the policyholder-insurer relationship may exceed the outer boundaries of the "business of insurance." Or, the interjection of insurer involvement into the relationship between two or more noninsurer entities in an effort to raise a McCarran Act shield for noninsurance activities from antitrust sanctions may also be beyond the outer limits. *See Battle v. Liberty National Life Insurance Co.,* 493 F.2d 39 (5th Cir. 1974), *cert. denied,* 419 U.S. 1110 (1975). Or, activities which have only a *de minimis* impact on the cost of insurance may also be outside the "business of insurance" sphere. *See Travelers Insurance Co. v. Blue Cross,* 481 F.2d 80 (3rd Cir.), *cert. denied,* 414 U.S. 1093 (1973). But, whatever the outer limits, it is clear that an insurer program aimed at the reduction or containment of the cost of insurance through its impact on the settlement and payment of claims is a part of the "business of insurance." Such a program very comfortably fits within the potentially more limited bounds of *Proctor* and even more easily within the parameters of the health cases discussed above.

The Blue Shield prepaid drug insurance program clearly is embraced by even the potentially more limited standard of *Proctor.* The program aims at the containment of costs. It does so by impacting on the claims settlement and payment process which is a substantial area for potential reduction in insurance costs. *See Proctor v. State Farm Mutual Automobile Insurance Co.,* 561 F.2d at 268-69 n.11. The Pharmacy Agreement provided

a means for the insurers to establish a claim settlement process and claim payment levels as well as introduce economic pressures for lower cost of drugs. Lower claim costs, in turn, enable lower insurance rates. As *Proctor* makes abundantly clear, the price of insurance, the handling of claims and the interrelationship of the two are part of the essence of the "business of insurance." Clearly, the Blue Shield program in this case was undertaken from the perspective of the insurer-insured relationship and consequently is a part of the "business of insurance."

B. The Decision of the Fifth Circuit Court of Appeals in the Instant Case is Premised on Several Reasons Which Are Factually Unsound and Legally Irrelevant.

Even though the fifth circuit has chosen to depart from the majority of courts which have found cost containment procedures by insurers to be part of the "business of insurance" under the McCarran Act, such departure would be understandable if the court had based its holding on sound legal reasoning. Unfortunately, this is not the case. The lower court's rationale for rejecting cost containment efforts as part of the "business of insurance" suffers from several unsound and irrelevant premises.

1. Pharmacy Relationships Are Not "Primary".

The lower court appears to accept the notion of the Respondents that the challenged activity "relate[s] primarily to relationships other than that between the insurer and its policyholder," 556 F.2d at 1380, and that "the relationship primarily affected by the Pharmacy Agreement . . . is that between competing pharmacies and not the relationship between insurer and insured." *Id.* at 1381. This

rationale lacks merit as a basis for decision for at least two reasons. First, insurer efforts to use the claims settlement process to control the cost of health care services and the premium rates directly affect every insured. The number of actual or potential insureds is literally conterminous with the extent of the entire population. Thus, the bald statement that the primary relationship involved is that between competing pharmacies lacks support in fact and reason. Quite the contrary, the primary relationship involved in this case is the one between the insurer and insured. Second, even assuming *arguendo* that there may be some question as to what is the primary relationship, the criteria enunciated by this Court in *National Securities* does not include primacy as a factor. *See* 393 U.S. at 453. This Court said that if the activity in question involves the "relationship between insurer and insured," it constitutes a part of the business of insurance. *Id.* at 460. There was no suggestion that the insurer-insured relationship had to be "primary." In short, the primacy argument is legally irrelevant as well as factually unsound.

2. Impact on Noninsurance Business is Not a Determining Factor.

There is some suggestion in the Fifth Circuit Court of Appeals' opinion that the more the conduct of the insurance business impacts on the noninsurance business, the less it becomes the "business of insurance." *See* 556 F.2d at 1383. This notion is also incorrect. The challenged activities in *Travelers, Frankford Hospital* and *Nankin Hospital* unquestionably affected the business of hospitals; the challenged activities in *Manasen* and *Anderson* undoubtedly impacted upon the business of dentistry and physicians; and the challenged activities in *Proctor* certainly impacted on the business of automobile repair. In

each case, however, the fact that the challenged activity impacted on some noninsurance business did not render such activity any less the "business of insurance."[5] Since a major function of an insurer is to be, in effect, a substitute purchaser of goods and services called for in the insurance contract, the "business of insurance" must necessarily impact on the suppliers of such goods and services. The District of Columbia Circuit Court of Appeals explicitly dealt with this question when it held that "the fact that a practice may affect other types of business is not dispositive of whether it is sufficiently related to the business of insurance to come within the McCarran Act's protection." *Proctor v. State Farm Mutual Automobile Insurance Co.*, 561 F.2d at 268.

3. The Rationale that Blue Shield is Not Obligated to Fix Drug Prices is Irrelevant.

A third rationale posed by the lower court as a basis for its decision is the conclusion that "Blue Shield is [not] obligated to fix the retail prices of pharmaceuticals." 556 F.2d at 1381. This rationale also fails on both factual and legal relevancy bases. First, categorizing the Blue Shield as a price fixing scheme is subject to question. As an insurer, Blue Shield is a substitute purchaser of prescription drugs. In mailing a copy of the Pharmacy Agreement to each licensed pharmacist, Blue Shield in effect extended an offer to purchase drugs at cost plus a $2.00 dispensing fee minus a maximum $2.00 deductible to be collected from the insured. Pharmacists, on an individual basis, decided whether to accept or reject this offer. The price payable is not uniform since the underlying cost can vary

[5] In this context, it should be noted that "[t]he plaintiffs [Respondents] concede that there may be effects on policyholders resulting from the Pharmacy Agreement," 556 F.2d at 1380, and "the contractual agreements here under review are somewhat related to the business of insurance." *Id.* at 1383-84.

from pharmacist to pharmacist. Furthermore, if the price offered by Blue Shield did not fall within reasonable market parameters, presumably most pharmacists would have rejected the offer. The mail offer technique used by Blue Shield, in effect, was one method by which a reasonable market price could be determined.

> In its negotiating with [suppliers of services, the insurer] has done no more than conduct its business as every rational enterprise does, i.e. get the best deal. *Travelers Insurance Co. v. Blue Cross,* 481 F.2d 80, 84 (3rd Cir.), *cert. denied,* 414 U.S. 1083 (1973).

Consequently, categorizing this activity as price fixing is a very questionable statement, particularly since there is no uniform rate.

Second, the Pharmacy Agreement is inextricably intertwined with Blue Shield's obligation under the insurance policy.[6] Prepaid health insurance issued by Blue Cross and Blue Shield obligates the insurer (Blue Shield in this case) to provide specified health care services to its insureds. "The basic function of Blue Cross [or Blue Shield] of providing prepaid hospital [or other types of health] care is clearly 'the business of insurance.'" *Nankin Hospital v. Michigan Hospital Service,* 361 F.Supp. 1199, 1211 (E.D. Mich. 1973). To meet these obligations, the insurer must contract with providers of health care services such as physicians, hospitals, dentists and pharmacists. The satisfaction of the claims for service is the responsibility of the insurer and as such is core of the

[6] This point is more fully developed in Petitioners' Brief. *See also* Petition For a Writ of Certiorari by Group Life & Health Insurance Co. at 10; Brief of Appellee Group Life & Health Insurance Co. at 17-20, Royal Drug Company, Inc. v. Group Life & Health Insurance Co., 556 F.2d 1375 (5th Cir. 1977).

business of insurance. *Proctor v. State Farm Mutual Automobile Insurance Co.*, 561 F.2d at 268. Determination of what to pay to whom in order for the service benefit of the policy to be provided is a fundamental aspect of the "business of insurance."

Finally, and most conclusively, even assuming *arguendo* that Blue Shield has no obligation under its insurance policy to enter into the Pharmacy Agreement, this Court in *National Securities* clearly indicated that activities other than the performance of contractual legal obligations between the insurer and insured may constitute a part of the "business of insurance."[7] For these various reasons, both individually and collectively, the "obligation" rationale of the lower court does not withstand scrutiny.

4. Application of "Peculiar to Insurance Business" Concept Does Not Support the Lower Court's Decision.

The Fifth Circuit Court of Appeals also appears to have based its decision on the grounds that the challenged activities — the cost control incentives associated with the Pharmacy Agreement — are not peculiar to the insurance industry and, consequently, do not constitute a part of the "business of insurance." 556 F.2d at 1383, 1386. However, the mere fact that an insurer engages in an activity whose nature is akin to the activities of noninsurers does not render the insurer's activity outside the "business of insurance." For example, setting a price for one's product or service is not peculiar to the insurance business. All enterprises must do so. Nevertheless, this Court has made abundantly clear that the "fixing of rates is a part of this

[7] For example, in *National Securities* this Court indicated that merger activities substantially involving the security of and service to be rendered to an insured is a part of the "business of insurance." 393 U.S. at 462.

business [of insurance]", *SEC v. National Securities, Inc.*, 393 U.S. at 459, even though it is not peculiar to insurance. Similarly, even though an insurer's efforts to contain its underlying costs are not peculiar to the insurance business, such fact does not divorce such efforts from the business of insurance. Furthermore, two of the cases cited by the lower court to support the "peculiar to the insurance industry" theory lead to the opposite conclusion.[8]

[8] The first case, *Center Insurance Agency, Inc. v. Byers*, CCH TRADE REG. REP. (1976-1 Trade Cases) ¶ 60,940, at 69,122 (N.D. Ill. 1976), involved one insurance agency attempt to pirate trade secrets concerning policy and advertising practices from another insurance agency. The district court concluded that this activity was not the business of insurance on the basis that "[t]he relationship between the insurance company and its policyholders was not involved and there was no effect on insurance rates." *Id.* at 69,125. Although the court referred to the "peculiar" concept, it was not faced with a factual setting which involved the "relationship between the insurer and the insured". Since the instant case involves an effect on rates and the insurer-insured relationship, the *Center Insurance Agency* case undermines rather than supports the Respondents' position.

The second case, *American Family Life Assurance Co. v. Planned Marketing Associates, Inc.*, 389 F.Supp. 1141 (E.D. Va. 1974), similarly involved efforts to induce one insurer's agents to switch to another company, to divulge trade secrets, etc. Here, too, the court interpreted *National Securities* to mean that the " 'business of insurance' pertained to activities *peculiar* to the insurance industry." *Id.* at 1145. But, similar to *Center Insurance Agency*, the court stated that "[a]cts peculiar to the insurance industry would include such things as the relationship between the insurer and the insured. . . ." *Id.* The lower court in the instant case failed to discern that these two decisions make clear that the "peculiarity" concept is not separate and independent of the basic standard that those activities involving the insurer-insured relationship are a part of the "business of insurance."

In addition, the lower court erroneously cites *American General Insurance Co. v. FTC*, 359 F.Supp. 887 (S.D. Tex. 1973), *aff'd*, 496 F.2d 197 (5th Cir. 1974) in support of the proposition that activities of insurers not peculiar to insurance companies are outside the scope of the McCarran Act. That case involved the application of the Clayton Act to a merger between two insurance companies. The insurer brought an action for declaratory and injunctive relief to de-

5. The Lower Court Succumbed to the Antitrust Rhetoric of Respondents.

Lacking a firm legal foundation upon which to base their argument concerning the "business of insurance" issue, the Respondents employed antitrust labels and rhetoric to "color" their case despite its lack of legal relevance. For example, the Respondents argued that

> DEFENDANT'S ACTIVITIES IN CONSPIRING AND AGREEING TO FIX RETAIL SALES PRICES, IN CONSPIRING TO EFFECT A BOYCOTT OF PLAINTIFFS, AND IN CONSPIRING TO FORECLOSE PLAINTIFFS FROM A SUBSTANTIAL PORTION OF THE MARKET DO NOT CONSTITUTE THE BUSINESS OF INSURANCE.[9]

Similar language is liberally sprinkled throughout the briefs of the Respondents.[10] In choosing this language, the

clare that the FTC lacked jurisdiction. The case was decided on the basis that the insurers had not yet exhausted their administrative remedies. 496 F.2d at 197. It was only in *dicta* that the district court addressed the McCarran Act issues. Furthermore, the court's discussion as to the business of insurance issue made no reference to an independent concept of "peculiarity," thereby providing no support to the Respondents' position in the instant case. And finally, it should be noted that the Fifth Circuit Court of Appeals affirmation in the *American General* case did not go to the district court's *dicta* but rather deferred the McCarran Act issues until there was a review of a final agency order. 496 F.2d at 197. Subsequent to the fifth circuit ruling the FTC has taken final administrative action, which is now being reviewed by the Ninth Circuit Court of Appeals. American General Insurance Co. v. FTC (No. 77-3207, filed December, 1977). It should be noted that the NAIC has filed an *amicus curiae* brief therein.

[9] Plaintiff's Brief in Opposition to Defendant's Motion to Dismiss at 13, Royal Drug Company, Inc. v. Group Life & Health Insurance Co., 415 F.Supp. 343 (W.D. Tex. 1976).

[10] For example, the Respondents assert conclusions of law as being facts in their Brief in Opposition to Petition for Writ of Certiorari at 6-12.

Respondents are using legal conclusions which cannot be arrived at until this case is tried on the merits under the antitrust laws. In fact, it would appear that such conclusions cannot be supported.[11] Furthermore, and even more important, Respondents' assertion that antitrust violations do not constitute the "business of insurance" is irrelevant since the application of the McCarran Act is not dependent upon a determination that there is no antitrust violation. *See Dexter v. Equitable Life Assurance Society,* 527 F.2d 233, 236 (2d Cir. 1975).

[11] Price fixing under section 1 of the Sherman Act may take one of two forms. One form involves vertical resale price maintenance which is irrelevant to the instant case. The second form refers to an arrangement between competitors. The essence of such price fixing is agreement with competitors. United States v. Citizens & Southern National Bank, 422 U.S. 86, 116 (1975); United States v. Columbia Pictures Corp., 169 F.Supp. 888, 893 (S.D.N.Y. 1959); Kiefer-Stewart Co. v. Seagrams & Son, 340 U.S. 211, 213 (1951).

The instant case contains no suggestion (1) that Blue Shield entered into any agreement with competing insurers, (2) that the success of Blue Shield's cost containment efforts depended upon Blue Shield inducing an agreement between competing pharmacists or (3) that, in the absence of the Blue Shield offer, competing pharmacists had any economic inducement to agree among themselves to charge a *lower* price. The fact that some of the participating pharmacists are also Respondents in this case challenging the Blue Shield Pharmacy Agreement strongly suggests that the inducement to enter into the Agreement was rooted in concern over competitors selling at lower prices not in a conspiracy among competing pharmacists. In short, the assertion of price fixing in the instant case, which requires a combination or conspiracy in restraint of trade, is not founded on economic sense.

Nor is mere parallel behavior among competitors sufficient by itself to show a conspiracy under section 1 of the Sherman Act. Theater Enterprises, Inc. v. Paramount Film Distributing Corp., 346 U.S. 537, 541 (1954). The crucial question in conspiracy cases is whether parallel business behavior could have been the product of independent decision. *Id.* at 540-41. *See also* Pevely Dairy Co. v. United States, 178 F.2d 363 (8th Cir. 1949), *cert. denied,* 339 U.S. 942 (1950). The facts in the instant case, including the absence of allegations that the participating pharmacists negotiated with one another, suggest that pharmacists' acceptance of the Blue Shield offer were the product of

Instead, appropriate analysis must avoid the facile use of conclusional rhetoric and look at the actual activities and facts which underlay the purported antitrust violations to determine whether such activities constitute the "business of insurance" under the McCarran Act. The Third Circuit Court of Appeals has noted the tendency in antitrust cases to employ antitrust "jargon" or labels as "a kind of semantic shell game, resting more on key words than on careful analysis." *Ungar v. Dunkin' Donuts of America, Inc.*, 531 F.2d 1211, 1222 (3rd Cir.), *cert. denied*, 429 U.S. 823 (1976). The Court itself has cautioned that the issues raised in antitrust litigation are not to be governed by labels or "key words" selected by counsel: "Invocation of mechanical word formulas cannot be made to substitute for adequate probative analysis," *FTC v. Sun Oil Co.*, 371 U.S. 505, 527 (1963). Unfortunately, in the instant case the lower court fell prey to the Respondents' use of antitrust conclusional labels in finding that the challenged activities were not the "business of insurance", 556 F.2d at 1381, 1383-4, 1386. As a consequence, the "coloring" of the court's perspective through its erroneous approach not only undercuts the persuasiveness of the decision, but also tends to explain the contorted rationale in the opinion.

In summary, the price which an insured pays for insurance is a fundamental element in the insurer-insured relationship, as are efforts to reduce or contain the underlying costs. As a consequence, such efforts are a part of

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independent judgment. Further indication that the Blue Shield program does not violate the federal antitrust laws is the Department of Justice determination, pursuant to its business review procedure, not to initiate any proceeding against a similar Blue Shield program. *See* Motion for Leave to File and Amicus Curiae Brief of Blue Shield Association in Support of the Petition for a Writ of Certiorari at 17a (Dep't of Justice Clearance of Jan. 15, 1968).

the "business of insurance," particularly when achieved through an impact on the settlement and payment of claims process. In applying the standards of *National Securities* several district and circuit courts have reached this very conclusion. The lower court's various rationales in the instant case, upon which the opposite result is premised, defy reason and lack legal relevance.

II. PUBLIC POLICY REQUIRES THAT INSURER EFFORTS AND PROCEDURES DESIGNED TO REDUCE OR CONTAIN THE COST OF INSURANCE BE CONSIDERED A PART OF THE "BUSINESS OF INSURANCE" UNDER THE McCARRAN ACT.

The aggregate cost of health care in the United States has soared tremendously in recent years.[12] The average annual percentage changes in medical care prices have substantially exceeded the inflation rate for other goods and services.[13] As a consequence, the escalation of costs in the delivery of health care has become a high priority government concern. Demands for national health insurance are tempered by the need to contain health care

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[12] Costs have soared from $12 billion in 1950 to $139 billion in 1976. U. S. DEP'T COMMERCE, BUREAU OF THE CENSUS, 1977 STATISTICAL ABSTRACT 94 (1977).

[13] There was a 9.3% increase in medical care costs in 1974, 12% in 1975 and 9.5% in 1976. *Id.* Between 1967 and 1976, the price of a semi-private hospital room has increased 169%, while physician fees increased 89%, dentists 72% and drugs 59%. *See id.* The average cost to a hospital for a patient's one-day stay reached $151 in 1975, and the average patient stay cost $1,164 in 1975. *Id.* at 98. If present inflation rates for hospital care continue, an average hospital stay will cost $2,600 by 1982. *Joint Hearings on H.R. 6575 Before the Subcomm. on Health of the House Comm. on Ways and Means and the Subcomm. on Health and the Environment of the House Comm. on Interstate and Foreign Commerce*, 95th Cong., 1st Sess. 13 (1977).

costs which have priced some segments of our society out of the market. The central public policy issue posed in this case is whether insurers, subject to appropriate state regulation, are to be part of the problem or part of the solution of controlling health care expenses.

A. The Public Policy of Health Care Cost Containment.

The escalating cost of delivering health care services to the American public has generated a growing consciousness among all segments of society that cost containment must be achieved before significant advances can be made in the quality and availability of existing health care programs. This consciousness is being translated into tangible public policy at all levels of government. Such policy is bringing substantial pressure to bear on insurers and state governments to undertake measures to contain or reduce the cost of health care.

1. Expressions of Public Policy.

The translation of public awareness of the importance of health care cost containment into public policy can be traced to a number of sources at both the federal and state levels.

a. Enunciated Federal Policy. Federal policy on health care cost escalation has been enunciated unequivocally by both the Congress and the Administrations of Presidents Ford and Carter. The Department of Health, Education and Welfare has given "highest priority to efforts directed toward the containment of health care costs."[14] The Federal Trade Commission has shown a re-

[14] U.S. DEP'T HEALTH, EDUC. & WELFARE, PUBLIC HEALTH SERVICE, FORWARD PLAN FOR HEALTH FY 1978-82, at 3 (1976).

cent interest in reducing the "inflationary aspects" of the Blue Shield reimbursement payment mechanism through limitations on fee increases and review of covered services.[15] These efforts, along with the President's hospital cost containment proposal,[16] reflect the federal government's commitment and pressure to contain health care costs.

Federal involvement in controlling the escalation of health costs has flowed especially from the creation and experience of federal health insurance programs. For example, combined Medicare and Medicaid expenditures by the federal government have risen from $9.9 billion in 1970 to an estimated $32.2 billion in 1977.[17] Within a few short years after the enactment of Medicare legislation, future cost projections were being revised markedly upwards because of soaring costs attributed to provider cost increases and greater than anticipated utilization rates.[18]

Experience with the federal insurance programs has led to numerous proposals and actions to contain costs. Congress in 1972 enacted substantial measures designed to control costs in Medicare and Medicaid through hos-

[15] *See Hearings Before the Subcomm. on Oversight and Investigations of the House Comm. on Interstate and Foreign Relations*, 95th Cong., 2d Sess. — (Mar. 21, 1978) (testimony of FTC Chairman Michael Pertschuk).

[16] *See Joint Hearings on H.R. 6575, supra* note 13.

[17] 1977 STATISTICAL ABSTRACT, *supra* note 12, at 249.

[18] STAFF OF THE SUBCOMM. ON HEALTH & THE ENVIRON. OF THE HOUSE COMM. ON INTERSTATE & FOREIGN COMMERCE, DATA ON THE MEDICAID PROGRAM: ELIGIBILITY, SERVICES, EXPENDITURES FISCAL YEARS 1966-76, 94th Cong., 1st Sess. 3 (1976).

pital cost and physician fee limitation authorities.[19] The House report accompanying the 1972 bill stated that

> Unfortunately a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. It is believed that they can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.[20]

In 1976, the Secretary of HEW noted the intensity of the federal government's response to cost escalation in saying that HEW "is vigorously attempting to control costs in the Federal programs through its hospital cost and physician fee limitation authorities obtained through the 1972 Social Security Amendments."[21] Furthermore, in the administration of Medicare by private insurance carriers, insurers are specifically authorized to make determinations as to the reasonableness of charges or costs.[22]

Other federal initiatives relevant to cost containment include professional standards review[23] and health maintenance organization legislation.[24] Professional Standards Review Organizations (PSRO) are charged with the responsibility of determining medical necessity in the rendering of health care in connection with federal in-

[19] *See, e.g.*, 42 U.S.C.A. §§ 1395b-1; 1395f(b); 1395u(b)(3); 1395y(d); 1396B(i) (1974).

[20] H. Rep. No. 92-231, 92d Cong., 2d Sess. (1972), *reprinted in* 3 U.S. CODE CONG. & AD. NEWS 4989, 5069 (1972).

[21] *Hearings on S. 3205 Before the Subcomm. on Health of the Senate Comm. on Finance*, 94th Cong., 2d Sess. 30 (1976).

[22] 42 U.S.C.A. §§ 1395u(a)(1), 1395u(a)(3) (1974).

[23] *See id.* §§ 1301, 1320c.

[24] *See id.* § 300e (Supp. 1977).

surance programs administered under social security. In acting upon PSRO legislation, it was the purpose of Congress to assure that payment for medical services would be made only when and to the extent of medical necessity. Federal health maintenance organization (HMO) legislation was intended to stimulate alternative delivery mechanisms for health care services. HMO's operate on a predetermined, prepaid premium basis which, in contrast to traditional fee-for-service payments, creates incentives to the provider of health care to operate efficiently.

Medicare and Medicaid reimbursement limitations, controls within the Federal Employees Health Benefit programs, HMO and PSRO legislation, and the hospital cost containment bills now pending before Congress are but several examples of congressional and federal policy on health care cost containment. Public policy, as enunciated through various federal insurance programs, calls for involvement of private insurance companies administering federal programs to affect the method and manner of reimbursement to providers of health care for the purpose of containing costs.

The intent of Congress to bring about cost efficiency in virtually all areas of the health care market is essentially manifest in the 1974 National Health Planning and Resource Development Act.[25] Congressional findings conclude that "[i]ncreases in the cost of health care . . . have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care."[26] Among the national health priorities identified by Congress in this Act is the development of simplified reimbursement methods for

[25] *Id.* § 300k (Supp. 1977).

[26] *Id.* § 300k(a)(4) (Supp. 1977).

health service institutions. To this end, grants for optional state rate regulatory programs were authorized. To qualify for grants, the state programs should "create incentives at each point in the delivery of health services for utilization of the most economical modes of service feasible" and employ methods "for determining the reimbursement rates . . . and . . . rates of change in the reimbursement rates. . . ."[27]

Bringing effective reimbursement controls to the health care market is a central objective of federal health planning policy. State authorized and supervised rate control mechanisms constitute one major approach. Alternative delivery modes, peer review and use of insurance company reimbursement leverage are also employed in the public and private sectors to influence the method and manner of reimbursement. Although various methods are employed, the federal government's policy to contain health care costs through the exercise of some control over provider reimbursement is clear.

b. Enunciated State Policy. Public policy as developed at the state level parallels federal objectives for cost containment initiatives. Pressures for cost controls come principally from those parties who bear the burden of paying for health care: government, third party payers, labor unions, corporations and private citizens. State governments have become financially involved in this cost spiral as their share of Medicaid program costs has pressured state budgets.[28] As a result, state efforts are now growing to bring about more effective cost controls on the health care market.

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[27] *Id.* § 300m-5(b)(2) (Supp. 1977).

[28] Data from 1974 reveals that state contributions to their Medicaid plans ranged from 17% to 50%, with state costs varying from $2 million in Wyoming to over $1 billion in New York. DATA ON THE MEDICAID PROGRAM, *supra*, note 18, at 27-28.

Governor Hugh Carey of New York, for example, is submitting legislation to secure a data base to monitor levels of payments to health care facilities. According to Governor Carey, "[e]ffective planning and control of health resources depends on controlling reimbursement rates paid to . . . hospitals and other health care facilities."[29] While the initial response of federal and state governments has been to control Medicare and Medicaid reimbursement levels, attention is being shifted towards all payer classes. Governor Carey's intent to monitor levels of payments evinces the broad reach of state interest.

Several states have enacted legislation creating cost containment agencies. For example, Maryland's Health Service Cost Review Commission was created

> to assure to all purchasers of health care institutional services that the cost of said institutions are reasonably related to the total services offered . . . and to provide that the rates set . . . are in reasonable relation to their aggregate cost. . . .[30]

Agencies similar to the Maryland Commission have been created in a number of other states and proposed in several more states.[31] The purpose of these enactments is to provide regulatory means to assure that health care facilities control capital expenditures, introduce incentives to operate efficiently and offer the lowest cost service possible while maintaining high quality care.

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[29] GOVERNOR HUGH L. CAREY, STATE OF THE HEALTH MESSAGE: SPECIAL MESSAGE TO THE NEW YORK LEGISLATURE 7 (Feb. 15, 1978).

[30] Synopsis to S.B. 359, ch. 627 [1971] Laws of Maryland 1129.

[31] *E.g.*, CONN. GEN. STAT. § 19-73i (1977); MASS. GEN. LAWS. ANN. ch. 6A, §§ 31-46 (Supp. 1977); WASH. REV. CODE ANN. § 70.39.160 (West 1975). *See also* Lemer & Willman, *Rate Setting*, in TOPICS IN HEALTH CARE FINANCING at 141-43 (Vol. 1, No. 2 1974).

State insurance regulatory interest in cost containment is longstanding. In the 1914 landmark decision, *German Alliance Insurance Co. v. Lewis,* 233 U.S. 389 (1914), this Court held that a commissioner of insurance could regulate insurance rates on the basis that insurance is affected with a public interest. In the health insurance area, the direct rate regulation of Blue Cross and Blue Shield in most states provides the insurance commissioner with leverage to encourage these insurers to undertake cost containment efforts. For example, in denying a recent Blue Cross rate increase request in Illinois, the Illinois Director of Insurance emphasized that "we should recognize the importance of vigorous and affirmative efforts by the state's largest health insurer to pressure cost containment."[32] In addition to directly regulating premium rates to subscribers, several states also regulate the rate of reimbursement to hospitals.[33] Because of the significance of the health care provider agreements with Blue Cross and Blue Shield, insurance regulatory interest in these contracts is hardly surprising:

> Hospital reimbursement schedules and doctors' fee schedules are at the core of the relationship between [Blue Cross and Blue Shield] associations and those who render services for subscribers. . . .[34]

Policy benefits, claims settlement procedures and premium rates are directly affected by reimbursement schedules. Statutory authority for insurance commissioner review of reimbursement agreements underscores both the

[32] National Underwriter, April 1, 1978, at 23, col. 1.

[33] *E.g.,* MICH. COMP. LAWS ANN. § 550.503 (Supp. 1978); OHIO REV. CODE ANN. § 1739.051 (Page Supp. 1976); PA. STAT. ANN. tit. 40, § 1558 (Purdon 1971).

[34] R. EILERS, REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS 178 (1963).

relationship of such agreements to the business of insurance and state policy to contain costs.

The states have also focused upon the development of health maintenance organizations (HMO's) as an alternative health care delivery system to, among other things, contain health care and health insurance costs. Although the federal government is engaged in providing start-up capital to HMO's under the Health Maintenance Organization Act of 1973,[35] HMO's are creatures of state law. Thirty states have moved since 1972 to provide special enabling legislation for HMO's.[36] Many of the state HMO laws are patterned after the Model HMO Act adopted by the NAIC in 1972.[37] The drafting comments to the NAIC Model Act explain that:

> An HMO, by its very nature, may provide incentive toward lessening costs in delivering health care. It

[35] *See* 42 U.S.C.A. § 300e-3 (1974).

[36] ARIZ. REV. STAT. ANN. § 20-1051 (Supp. 1977); ARK. STAT. ANN. § 66-5201 (Supp. 1975); CAL. HEALTH & SAFETY CODE § 1304 (West Supp. 1976); COL. REV. STAT. ANN. § 10-17-101 (Supp. 1976); FLA. STAT. ANN. § 641.17 (Supp. 1977); IDAHO CODE § 41-3901 (1977); ILL. ANN. STAT. ch. 111.5, § 1401 (Supp. 1977); IOWA CODE § 514B.1 (1977); KAN. STAT. ANN. § 40-3201 (Supp. 1976); KY. REV. STAT. ANN. § 304.38-010 (Baldwin Supp. 1978); ME. REV. STAT. ANN. tit. 24-A, § 4201 (West Supp. 1977); MD. ANN. CODE art. 43, § 840 (Supp. 1977); MASS. GEN. LAWS ANN. ch. 176G, § 1 (West Supp. 1977); MICH. COMP. LAWS ANN. § 325-901 (Supp. 1978); MINN. STAT. ANN. § 62D.01 (Supp. 1978); NEV. REV. STAT. ch. 695C.010 (1975); N.H. REV. STAT. ANN. § 420-B:1 (Supp. 1977); N.J. STAT. ANN. § 26:2I-1 (Supp. 1977); N.Y. PUB. HEALTH LAW § 4400 (McKinney Supp. 1976); N.C. GEN. STAT. § 57A-1 (Supp. 1977); N.D. CENT. CODE § 26-38-01 (1977); OHIO REV. CODE ANN. § 1742.01 (Page Supp. 1976); PA. STAT. ANN. tit. 40, § 1551 (Purdon Supp. 1975); S.C. CODE ANN. § 37-1131 (Supp. 1975); S.D. COMP. LAWS ANN. § 58-41-1 (Supp. 1976); TENN. CODE ANN. § 56-4101 (Supp. 1976); TEX. INS. CODE art. 20A.01 (Vernon Supp. 1975); UTAH CODE ANN. § 31-42-1 (1974); WASH. REV. CODE ANN. § 48.46.010 (West Supp. 1976); W. VA. CODE ANN. § 33-25A-1 (1977).

[37] I NAIC PROCEEDINGS 202-22 (1973).

> has a limited membership prepaying fixed sums of money. The providers are obligated to deliver a specified set of health care services. The fixed amount of income provides incentive to control expenses and costs.[38]

Substantial state interest in HMO's and insurance regulatory encouragement and involvement further evidence the policy of the states to implement effective cost containment.

Some possibilities for the direction of future insurance industry involvement in containing costs may be gleaned from the NAIC's recently adopted Model Comprehensive Health Insurance and Health Care Cost Containment Act.[39] This model calls for the mandatory offering by insurers of a particular form of comprehensive coverage that includes substantial cost sharing features, extensive health care provider cost controls and other innovative measures to accomplish cost efficiency. Health care provider payment provisions of the model bill authorize insurers to: (1) determine the necessity of care and the reasonableness or adherence to customary charges by providers; and (2) enter into negotiations and agreements for the establishment of direct payment plans under which insurance company payments are accepted in full satisfaction of provider charges.[40]

The involvement of the health insurance industry in limiting the tendency of providers of care to charge whatever insurers can pay is essential in the opinion of the NAIC. State policy to effectuate health care cost containment is clearly evidenced by hospital cost control legisla-

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[38] *Id.* at 204.

[39] II NAIC PROCEEDINGS 407-37 (1976).

[40] *Id.* § 14, at 424-25.

tion, HMO legislation and the activities of insurance regulatory authorities.

2. The Root Causes of Escalating Health Care Costs Require Experimentation With a Variety of Cost Containment Measures.

Both federal and state public policies toward health care cost containment are in the formative stages of development. If these policies are to be implemented successfully they must be allowed wide latitude in experimenting with mechanisms which can be employed to ameliorate the root causes of cost escalation.

a. The Root Causes of Cost Escalation. Two basic causes underlie the escalation of health care costs and hence the cost of health insurance. *First, the operation of the medical care system lacks internal incentives for cost constraint and contains internal incentives that result in cost escalation.* These include, for example, (a) fee for service which provides economic reward for utilizing more services and more expensive services, (b) retrospective cost reimbursement for institutional providers, (c) prestige of high cost specialization, (d) concentration of providers in areas with good facilities, and (e) excess hospital bed capacity in many areas causing higher unit costs and incentive to increase utilization beyond needed levels to recover fixed cost of under-utilized services and facilities.

Second, the third party system (whether a government program such as Medicare or Medicaid or private insurance) insulates those who make the decision concerning the nature and quantity of health care services — the patient and the physician — from the direct economic consequences of such decisions. This third party payment system eliminates the major restraint for the demand for

health care services whether or not they are medically necessary.[41] In other words, competition is ineffective in maintaining a proper market for health services:

> The immunity of the hospital industry from the traditional incentives and penalties of the free enterprise system . . . is the critical factor in the uninhibited rise of hospital charges and costs.
>
> . . . .
>
> The user of the service — the patient — rarely pays. Ninety percent of the hospital bills are paid by third party payers. Thus, the patient never has a sense of the exorbitant price of the service he receives.
>
> The user of the service — the patient — does not choose the service. His doctor usually tells the patient what he needs. The current system of third party payers reimbursing hospitals for whatever the cost-plus, sole source price is, has created a "spend-more, get-more" attitude.[42]

Since the physician typically selects the mode and extent of hospital, medical, prescription and other related health care services, both the demand and supply decisions tend to coalesce under the physician's control. Thus, the decisions in the health care field are primarily made by persons with few incentives and several disincentives to deliver health care in a reasonably economic and efficient

[41] The underlying structural characteristics of the health care industry, the prevelance of public private insurance coverage, and the reimbursement practices of these third parties have resulted in chronic inflation in health care costs. . . . The inflationary effects of these reimbursement methods are clearly exaggerated by the virtual guarantee of payment by a public or private insurer and the dependence of the consumer on the medical care provider. *Hearings on S. 3205, supra* note 21, at 29-30. *See also* FORWARD PLAN FOR HEALTH, *supra* note 14, at 32; M. FELDSTEIN, THE RISING COST OF HOSPITAL CARE 76 (1976).

[42] *Joint Hearings on H.R. 6575, supra* note 13, at 14.

manner.[43] Cost escalation for all insured health services is an unfortunate byproduct of the third party payment system and the lack of effective competition in health care delivery.

b. The Need for Experimentation With Methods to Contain Health Care Costs. Increasing coverage under third party insurance payment systems (whether government or private) emphasizes the necessity for an improved cost containment system. Various approaches and techniques have been suggested and/or experimented with to contain the escalation of health care costs.

(1) Rate Controls. One approach which has been developed to reduce costs is the direct imposition of rate controls on hospitals and physicians by government. For example, the imposition of a rate review system over hospital costs and charges offers a means to interject cost constraint incentives into the administration of health care delivery systems leading towards improved budgeting, justification of capital expenditures and development of internal systems to monitor costs. Cost restraint incentives can likewise be created for physician fees through such actual and suggested techniques as professionally-established rate schedules, peer review of the reasonableness of fees, negotiated fee schedules and government-mandated charges. On the other hand, there are indications that governmental control of hospital and physician charges lacks effectiveness, poses administrative difficulties, and may adversely affect the quality of health care.

[43] To the extent that potential medical malpractice liability induces the practice of "defensive medicine" by physicians, overutilization of health care resources is further aggravated. *See* U.S. DEP'T OF HEALTH EDUC. & WELFARE, REPORT OF THE SECRETARY'S COMM. ON MEDICAL MALPRACTICE 14 (1973).

The extent to which a government should become involved in the delivery of health care raises a fundamental public policy question. It should be noted that direct regulation functions most efficiently when only a few large organizations are involved. In contrast, comprehensive regulation of the health care delivery system with its large number of small units (e.g., hospitals, physicians) is likely to be very complex, thus generating pressure over a period of time to consolidate into a relatively few delivery units. A potential result of direct government regulation of rates, then, is a more centralized health care delivery system which is less attuned to local circumstances and individual needs than the present system. This additional consideration also suggests that there may be limits to the feasibility of government rate controls as a cost control mechanism.

(2) Cost Sharing. A second general approach to containing the cost escalation inherent in the third party payment mechanism is to require cost sharing by the consumer. If the consumer significantly bears a direct and visible portion of the cost of using health care at the point of service, he may be induced to economize in the selection and use of services. Various cost sharing devices include insurance policy deductibles, coinsurance, exclusions and/or maximum coverage limits. Although these techniques may be effective in inducing persons to refrain from seeking health care services, they may also raise inappropriate barriers to needed care. Thus, the design of the deductibles must be carefully considered. There is no assurance that this approach will encourage sufficient cost containment and simultaneously avoid deterrence to needed care.

(3) Insurer Cost Containment Efforts. A variant on both the direct government control and consumer cost sharing approaches to cost containment is to vest authority and responsibility in insurers, subject to state regulatory oversight. A variety of techniques and approaches are available to insurers, with a most promising one being to allow or encourage insurers to negotiate prices of health care purchased by insurance benefits. Negotiated reimbursement contracts of Blue Cross and Blue Shield are current examples of this approach. Although not endorsing this approach as necessarily the only or best method, several reasons commend it as an appropriate and worthwhile approach.

First, as evidenced by statutory language, regulations and policy statements, there is widespread feeling that, since the private insurance system (as well as the government insurance program) is a prime cause in the escalation of health care costs, it should also bear major responsibility in containing costs. Second, a health insurer is in effect a substitute purchaser of consumer services. As such it may have market power to bring pressure on health care providers' prices, quality and patients' utilization of services while acting in the best interests of its insured-health care consumers. Third, the private insurance system has undertaken a wide variety of programs to contain costs. As a general proposition, it is usually better to build upon and improve an existing system than to start from scratch. This is particularly true in the absence of convincing evidence of the superiority of alternative approaches. Fourth, the delivery of health care is a very multi-faceted industry requiring a variety of cost measures. Utilization of the private insurance industry makes available an existing vast resource of people and funds to tackle the cost containment problems on a flexible and local basis.

It is not the purpose of this *amicus curiae* brief to resolve the multitude of public policy questions pertaining to the containment of health care costs and, thereby, the containment of the costs of health insurance and other types of insurance coverages which provide health benefits. By virtue of this brief, however, the NAIC hopes to provide some indication of the breadth of the problem and the urgent need to experiment with a variety of approaches in order to find acceptable and effective solutions. One of the most promising approaches is vesting authority and responsibility in insurers, subject to appropriate state regulation, to develop and implement cost containment measures. But certitude concerning the merits of various programs and the best balance in combining various programs is still on the distant horizon. Thus, continued effort and experimentation with promising approaches is essential if the public policy of health care and health insurance cost containment is to be achieved.

3. Implications of the Lower Court's Decision for the Public Policy of Health Care Cost Containment.

By finding that the Blue Shield program does not constitute the "business of insurance," the lower court in the instant case exhibited little reluctance to deny an insurer a role in the containment of health care costs. The court explicitly stated that

> Blue Shield is not required to guarantee the provision of services on a "cost plus" basis *or any* other *basis which might be more economical* than the retail purchase of such products. That Blue Shield may wish to protect itself and its consumers from rising costs in the pharmaceutical industry does not transform the Pharmacy Agreement into the business of insurance. In fact, *the best way for the firm to protect itself from rising costs is to establish and periodically adjust its rate structure to reflect the impact of inflation.* 556 F.2d at 1382 (emphasis added).

The court sees the insurer's role as nothing more than a bill payer with no responsibility to contain the underlying costs and no proper interest in making health insurance available to the consumer at a lower price. There are serious public policy ramifications of such a narrow perspective of an insurer's role in cost containment.

The lower court's perception of the insurer's role ignores economic reality. Because of the volume of reimbursement payments it is obligated to make, an insurer's activities inevitably impact upon the market for services of health care providers. An insurer cannot escape responsibility for contributing to the escalation of health care costs due to the inherent nature of the third party payment system. By denying insurers an opportunity to assume this responsibility and respond to public pressures, the lower court runs roughshod over the public's need for limits on health care expenditures. Such result directly conflicts with the public policy of health care cost containment enunciated at both federal and state levels of government.[44]

B. The Public Policy of Cost Containment in Other Lines of Insurance.

The public policy supporting cost containment initiatives by health insurers is parallelled by expressions of public policy applicable to other lines of insurance. An example of insurance cost problems outside the health care context is the testimony of the National Traffic Safety Administrator before the Senate Commerce Committee that consumers "spend about $13-17 billion in the

[44] *See* notes 14-40 *supra* and accompanying text.

United States on unnecessary automotive repairs."[45] One study demonstrates that replacement of all parts on a totally wrecked 1977 standard automobile with a list price of $4,631 would produce an aggregate repair bill of $21,471.[46] Escalation in prices of automobile repair parts has, similar to medical care, outpaced the inflation rate for other goods and services.[47] Under automobile liability coverages, an insurer in effect is a mass purchaser of medical services, legal services and car repairs. The inflationary pressures in these areas, in turn, impact upon the cost of insurance. Without review of the reasonableness of charges, automobile insurers and their policyholders would be subject to uncontrolled inflation in the repair market.

If the fifth circuit's decision is affirmed by this Court, the precedent thus set is likely to cause insurers to avoid practices that may be construed as efforts to affect the method of reimbursement to those providing services to insureds. If insurance company efforts to control reimbursement rates to health care providers give rise to antitrust violations, reimbursement controls in other lines of insurance will be similarly subject to challenge. The sanction of cost containment efforts offered by *Proctor v. State Farm Mutual Automobile Insurance Co.*, 561 F.2d 262 (D.C. Cir. 1977) would be undermined. Compelling the insurance mechanism merely to indemnify insureds for their purchase of lost or damaged goods or services will

[45] *Hearings on S. 2604 Before the Subcomm. on the Consumer of the Senate Comm. on Commerce, Science and Transportation,* 95th Cong., 2d Sess. — (Mar. 21, 1978) (testimony of Joan Claybrook, Administrator, National Highway Traffic Safety Administration).

[46] *What's Driving Up Auto Insurance Costs?* 53 J. OF AMERICAN INSURANCE 9 (Spring 1977).

[47] Between 1972 and 1977, the average insurance loss payment per collision claim increased more than 54%. *Id.*

exacerbate the pattern of increased loss payments which are passed directly and immediately to policyholders in the form of higher prices. We perceive no public benefit or offset to the added cost burden that would result from providers of insured goods and services being free to exploit the third party insurance payment mechanism. Public policy could not be more obviously violated.

C. The Public Policy of State Insurance Regulation.

1. Continuing State Regulation.

The basic purpose of the McCarran Act is quite clear. Congress has declared that "the continued regulation . . . by the several states of the business of insurance is in the public interest . . ." 15 U.S.C. § 1011 (1970). Shortly after its enactment, this Court said "[o]bviously Congress' purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance." *Prudential Insurance Co. v. Benjamin,* 328 U.S. 408, 429 (1946). This Court more recently affirmed this conclusion in *SEC v. National Securities, Inc.,* 393 U.S. 453, 459 (1969) when it said that the McCarran Act was an attempt "to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation." There are strong public policy considerations supporting this congressional mandate.[48]

[48] These public policy considerations are, first, that state regulation of insurance is closer to the people. Because major problems in insurance regulation involve local market conditions — availability of coverage, the price of coverage and the handling of claims — both the means and the incentives to regulate the market conduct of insurers are better handled at the state level. *See* Stewart, *Pressure and Results in Insurance Regulation,* in REASON & REGULATION, SELECTED SPEECHES OF RICHARD E. STEWART 49 (1971). An insurance commissioner and top members of his staff, for example, are more accessible

The lower court's decision works contrary to the congressional intent under the McCarran Act as interpreted

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to personally respond to public needs than their counterparts in the federal bureaucracy.

Second, state regulation offers many advantages of pluralism, experimentation and diversity of regulatory philosophy. *See id.* at 49-50; S. KIMBALL & H. DENENBERG, INSURANCE, GOVERNMENT, & SOCIAL POLICY 415 (1969). A decentralized system of insurance regulation provides maximum flexibility while tailoring regulatory efforts to individual needs. The dispersion of decisional responsibility and power tends to restrict gravity of mistakes and miscalculations while simultaneously encouraging adoption of innovative techniques which have been tested and proven workable elsewhere.

Third, it is significant that there already exists an ongoing and time-tested system for regulating insurance at the state level. Stewart, *supra,* at 47-48. No industry could have thrived for the past one hundred years to the extent of the insurance industry if either the philosophy or administration of state regulation had been unsound. If regulatory jurisdiction over the insurance industry is transferred from state government to the federal government — either gradually or in one step — much of the experience and expertise now residing in state insurance departments would be lost.

Fourth, an extremely important and unique advantage of state insurance regulation is the system of governmental accountability due to the threat of a federal alternative. Because state insurance regulation is subject to extinction by Congress, state regulators are particularly sensitive to congressional oversight — more so than federal agencies to which there is no credible alternative. *Id.* at 50.

Finally, there is much to be said for preserving the concept of federalism by delegating to the states the authority to regulate the business of insurance. As our recent national experience with abuses of presidential power suggest,

> Decentralization and dispersion of political power is in itself an important value in a democratic society. Concentrations of power are bad, per se, and it is irrelevant whether the concentrations are in government, in labor, or in business. . . . Any problems that can be dealt with adequately at the state level *should* be handled there in preference to Washington. S. KIMBALL & H. DENENBERG, *supra,* at 416.

Senator Ferguson voiced identical concerns when he noted in the debates surrounding the McCarran-Ferguson Act: "[W]e believe that all the wisdom is not here in Congress." 91 CONG. REC. 1481 (1945).

by this Court. By unduly narrowing the definition of what constitutes a part of the "business of insurance" the lower court would subject certain insurance activtities to antitrust sanctions; this result would impede the ability of the states to regulate insurance by injecting tremendous uncertainty into the scope of insurance regulation. This is particularly evident where state insurance commissioners review efforts by insurers to foster and sanction lower insurance costs.

2. Allocation of Regulatory Responsibility Over Insurance Cost Containment.

The lower court's decision poses ramifications extending far beyond the facts in the instant case and the interests of the immediate parties involved. The determination whether an insurer's efforts to reduce or contain the cost of insurance constitutes a part of the "business of insurance" also determines the allocation of regulatory responsibility for containing such costs. Reaffirmation of the decisions in numerous district and circuit courts, with the corresponding reversal or modification of the Fifth Circuit Court of Appeals' decision in the instant case, would leave primary responsibility with the states vis-a-vis the federal antitrust laws. Affirmation of the firth circuit decision would either deter or foreclose a variety of state mandated or sanctioned efforts to resolve the cost containment problems.

A fundamental public policy issue before this Court, therefore, is who should determine the metes and bounds of appropriate activity designed to contain insurance costs? Should the responsibility be vested in the federal courts under the antitrust laws in the context of *ad hoc* litigation or in the state insurance commissioner in the context of continuous administrative supervision?

[T]he more knowledgeable consumer sees insurance regulation as serving three goals. (1) He wants to be able to buy insurance — conveniently — to get what he needs. (2) The insurance must be reasonably priced. (3) The insurance must be good — that is, the company should be able, at all times, to discharge the financial obligations it has assumed in its contract. These three objectives are sometimes wrapped up in three words: (1) availability, (2) price, and (3) solidity.

If the prospective insured cannot obtain insurance at all, price and solvency become immaterial. Or, if the insurance is available but the price is so high as to put the coverage out of reach for all pracical purposes, solvency is again immaterial. When a company fails, the availability of coverage in the first instance or the price charged for it becomes immaterial. Lack of solidity then becomes an important consideration. There is increasing recognition that all three goals are tied together.[49]

Each insurance commissioner is on the public "firing line" to achieve publicly perceived objectives of insurance regulation — availability of insurance, reasonable price, fair treatment of claims and insurer reliability. To achieve these insurance regulatory goals, extensive insurance regulation has evolved in the various states in such areas as rating laws, policy form controls, solvency standards, approval mechanisms as to reimbursement contracts with health care providers, unfair trade practices acts, etc. The manner in which insurers are to provide insurance benefits to insureds at reasonable rates is the very type of regulatory problem which state insurance commissioners are the most competent to examine. The

[49] J. Hanson, R. Dineen & M. Johnson, Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business 98 (1974).

insurance commissioner deals directly with the *substance* and *fairness* of the interrelated insurance regulatory problems of which cost containment is one. In contrast, application of the federal antitrust laws deals more with the *form* rather than *substance* of market activity in its pursuit of the question whether or not there is a conspiracy in restraint of trade.[50] In short, the state insurance commissioner is better positioned to come to grips with the problems relating to containing underlying cost of insurance and balancing the interests of individual claimants and those policyholders who fund the insurance benefit mechanism through premium payments.

D. The Public Policy of Antitrust and Its Relation to Health Care Costs.

The fifth circuit would subject Petitioners' cost containment activities to antitrust scrutiny and possible sanctions. A fundamental objective of the antitrust laws is to encourage the "lowest prices" for goods and services in the marketplace. *See Northern Pacific Railway Co. v. United States,* 356 U.S. 1, 4 (1958). *See also United States v. International Harvester Co.,* 274 U.S. 693, 701 (1927). Antitrust attempts to achieve its goals through the maintenance of competitive markets. Report of the Attorney General's National Committee to Study Antitrust Laws 1 (1955).

In the fact situation of the instant case, Blue Shield extended an offer through the mail to each individual pharmacy owner to participate under an agreement for providing drugs to Blue Shield policyholders at a price contractually agreed to be the pharmacist's acquisition

[50] *See* P. Asch, Economic Theory and the Antitrust Dilemma 281-84 (1970).

cost plus a $2.00 dispensing fee. Each pharmacy was free to accept or reject the offer. The individual offers made to pharmacies in and of themselves posed a reasonable means to determine an adequate and reasonable reimbursement rate. The acceptance of the offer individually by several pharmacies, including certain individual Respondents,[51] suggests an adequate level of reimbursement. The fact that Blue Shield's reimbursement plan was effective in putting downward pressure on retail drug prices suggests that competition had not previously fully encouraged the lowest possible prices.[52] Thus, in effect, we have the spectacle of the Respondents urging that the antitrust laws be used to avoid the "lowest prices" contrary to the basic purpose of antitrust laws.[53] To construe the term "business of insurance" not to include an insurer program aimed at the reduction or containment of the cost of insurance would uphold a perverse application of the antitrust laws and ignore economic reality.

Moreover, the structure of the health care delivery system does not fit within the parameters of what is needed for an effective competitive market. Reliance on the application of the antitrust laws as the primary mechanism to contain costs would not only be an illusion, it could also deter or prohibit other promising approaches. For

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[51] Nine Respondents accepted the Pharmacy Agreement offered by Petitioners. 556 F.2d at 1378.

[52] While price escalation for drugs in recent years has been below that for other medical costs, third party prescription drug coverage has only recently become widespread. *See* 1977 STATISTICAL ABSTRACT, *supra* note 12, at 97. To the extent that third party reimbursement is responsible for general health care cost escalation, the recent trend towards prepaid drug coverage can be expected to generate price escalation paralleling that for other health services.

[53] Respondents alleged that the Pharmacy Agreement set prices at a level below that at which some of the small independent pharmacies could profitably operate. 556 F.2d at 1375, 1378.

this reason, the public policy of antitrust does not support the lower court's decision in the instant case whereas the other public policies demand that the decision be reversed.[54]

The Respondents also suggest that, if the challenged activities of Blue Shield are claimed to be the business of insurance, private insurers would enjoy untrammelled freedom to enter into contracts with suppliers of goods and services thereby setting prices in various segments of the economy. This contention lacks merit for at least two reasons, First, even if a challenged activity constitutes the "business of insurance" the McCarran Act still does not bar the application of the antitrust laws if the state has not regulated or if the activity constitutes a boycott, coercion or intimidation. Thus, in the type of situation presented by the instant case, if the state does not afford protection by regulating an insurer's activity to reduce or contain costs, the antitrust laws would still apply. Second, as noted earlier, the NAIC does not maintain that there are no outer limits to what constitutes the "business of insurance." But, from both legal and public policy viewpoints, insurer efforts to reduce or contain the cost of insurance through claims settlement procedures clearly and comfortably fits within these limits. The state regulation and boycott provisions of the McCarran Act and the limited standard submitted by the NAIC in this instant case

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[54] In this connection, it is interesting to note that the current chairman of the FTC, one of the two federal antitrust enforcement agencies, has suggested that "Blue Shield plans could take steps to reduce these inflationary aspects of their payment mechanisms." *Hearings Before the Subcomm. on Oversight and Investigations, supra* note 15, at ——.

militate against the Respondents' alleged fears of unrestrained private activity.[55]

The foregoing discussion confirms the general awareness and recognition that there exists a strong public policy to reduce or contain those costs which underlay the cost of insurance with particular reference to such areas as health care. In addition the McCarran Act has long established the sound public policy of vesting primary responsibility in the states for regulating the business of insurance. As a result, as between the states and federal antitrust, there is further public policy of allocating to the state insurance regulators the primary responsibility to reduce or contain costs of insurance. Each of these public policies urge reversal of the lower court's decision in the instant case.

The Respondents, however, are asserting that the public policy of the antitrust laws lead to the contrary conclusion. In construing the scope of the "business of insurance" in the existing case, this Court is inescapably confronted with the problem of balancing these sometimes competing public policies. However, the affirmance of the lower court's decision in this case would not only ignore the major public policies of (1) health care and insurance cost containment, (2) continued state insurance regulation, and (3) allocation of regulatory responsibility for cost containment to the states, such affirmation would also uphold a perverse application of the antitrust laws and defeat the antitrust public policy of lower costs.

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[55] In evaluating the Respondents' argument, it is worth noting that it is premised on economic *un*reality. The Repondents would have the courts believe that the various segments of the economy can be compartmentalized and not impact upon each other. This is obviously in error. An insurer is, in effect, a substitute consumer of large quantities of products and services. As such, the insurer will impact on the price structure in those markets regardless of the existence of a written contract.

SUMMARY OF ARGUMENT

The price which an insured pays for insurance is a fundamental element of the "business of insurance" under the McCarran Act. It follows that efforts to contain escalating prices must likewise be considered a part of the "business of insurance"; they significantly affect the insurer-insured relationship through their impact on the rate paid to insurers by insureds. In applying the standards of the *National Securities* case several circuit and district courts have reached this very conclusion. The lower court's various rationales in the instant case, upon which the opposite result is based, defy reason and lack legal relevance.

But more importantly, the public policy of health care cost containment dictates that insurer cost control efforts be considered a part of the "business of insurance." Although there are several approaches available for halting the escalating spiral of modern health care costs, one extremely attractive approach is the claims settlement procedures of insurers which focus on cost containment. The lower court's decision would nullify these procedures by allowing providers of goods and services to avoid their cost-limiting impact. Given proper regulatory supervision under state insurance laws, the NAIC believes that cost containment efforts of insurers which focus on claims settlement procedures will not overstep the bounds of acceptable economic conduct. The public policy of health care cost containment requires that such efforts at least be given an opportunity to counteract the forces which generate spiraling insurance costs.

The public policy of health care cost containment is not the only public policy which necessitates a finding

that insurer cost control efforts be considered a part of the "business of insurance." Because the Court's decision in this case will affect cost control efforts of insurers in other lines of insurance, the broader public policy of minimizing all types of insurance costs supports the position that cost containment efforts be included within the phrase "business of insurance." Similarly, the public policy of continued state insurance regulation, as embodied in the McCarran Act, leads to the conclusion that cost containment efforts of insurers be considered the "business of insurance." Even the public policy of "lowest prices" under the antitrust laws offers more support to the Petitioners' view of the "business of insurance" than to the lower court's narrow perspective. If that court's decision is upheld by this Court there is little doubt that various public policies will be seriously compromised at the expense of illusory antitrust objectives.

CONCLUSION

The NAIC believes that the lower court's decision in this case precludes an essential alternative for curbing the spiraling costs of health care services today — insurer cost containment efforts — by making such efforts vulnerable to antitrust litigation. Sound logic, legal precedent and public policy dictates that an insurer's activities designed to reduce or contain the cost of health care be considered a part of the "business of insurance under the McCarran Act and exempted from antitrust sanctions. Any other result would do a great disservice to the insurance-consuming public.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR AMICUS CURIAE MOTOR VEHICLE MANUFACTURERS ASSOCIATION OF THE UNITED STATES, INC.

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On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF FOR AMICUS CURIAE MOTOR VEHICLE MANUFACTURERS ASSOCIATION OF THE UNITED STATES, INC.

All parties have consented to the filing of this brief for amicus curiae in support of Petitioners, pursuant to Rule 42(2) of this Court.*

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* *See* Letter to Mr. Rodak from counsel for Petitioners and Respondents (April 10, 1978).

INTEREST OF AMICUS

The Motor Vehicle Manufacturers Association of the United States, Inc. ("MVMA") is a voluntary, nonprofit membership association composed of companies engaged in the production of motor vehicles in the United States.[1] MVMA's member companies employ in excess of 900,000 workers, the majority of whom are represented by the United Auto Workers and other unions.[2] Each member company provides comprehensive group health insurance benefits to its employees. These plans typically cover hospital care, medical care, dental care, vision care and hearing care, as well as the cost of prescription drugs. Premiums for this health insurance approach two billion dollars.

These group health insurance plans usually contain provisions requiring that the insurer contract in advance with providers of health care to furnish services to the insured employees. These arrangements are a result of collective bargaining, and they provide employees with greater risk coverage and insurance benefits than could otherwise have been available. Indeed, the Blue Shield of Texas drug insurance policy involved in this case was first issued as a result of a collective bargaining agreement between certain MVMA members and the United Auto Workers.

The Court of Appeals for the Fifth Circuit has decided that contractual arrangements with health pro-

[1] The member companies of MVMA are: American Motors Corporation, Checker Motors Corporation, Chrysler Corporation, Ford Motor Company, Freightliner Corporation, General Motors Corporation, International Harvester Company, PACCAR, Inc., The Nolan Company, Walter Motor Truck Company, White Motor Corporation.

[2] These employees share MVMA's interest in this case. This interest is presented in the *amicus* brief filed by the United Auto Workers and the AFL-CIO.

viders are not part of the business of insurance. The court's decision places in jeopardy a long-standing system of regulation applicable to these health insurance programs. It touches upon insurance coverages which employees have obtained through the collective bargaining process. It threatens the stability of one of the few effective means available to the companies and their employees to control rapidly rising health insurance costs.

These matters vitally concern MVMA's member companies. They have a direct interest in their employees' health needs and bargaining demands for health insurance; health care provisions are significant factors in employee performance and industrial stability.[3] Moreover, since the companies pay a large part of the premiums for health insurance, they have a direct interest in the efficiency of delivery systems for medical care and payment.

SUMMARY OF ARGUMENT

Contractual arrangements between insurers and providers of health services and prescription drugs are a traditional form of health insurance and a common and widespread feature of insurance plans and policies. Such arrangements afford a distinct form of protection to the insured against specific risks. Thus, they are central to the insurer-insured relationship. Moreover, these contractual arrangements serve another function recognized by this Court to be at the core of the "business of insurance"—the control of the cost of insurance. For these reasons, both insured employees and their employers have demanded provisions in their insurance plans requiring the insurer to enter into such arrangements.

[3] Proposed changes in health and pension provisions were significant causes of the recent prolonged strike in the coal industry. *See* Board of Inquiry, *Report to the President on Labor Disputes Affecting the Bituminous Coal Industry in the United States* (March 9, 1978).

These arrangements are, in fact, one of the few effective means to control rapidly rising health care costs. The federal and state governments, under Medicare and Medicaid programs, use the same arrangements. Many state regulators are now emphasizing that the arrangements be employed in order to keep insurance protection available at reasonable rates.

In the light of the widespread recognition of the essential role of these arrangements in the provision of health insurance protection, it makes no sense to hold that such common practices are not part of the "business of insurance," and Congress could not have intended such a result. As this Court has held, where a practice intimately affects both the type of insurance protection available to the insured and the cost of such protection, Congress determined that the public policy interests embodied in state regulation of the practice outweigh the policy interests expressed in the antitrust laws. Of course, if an insurance practice constitutes an "act of boycott, coercion, or intimidation," or if there is no state regulation of the practice, Congress has given primacy to the policies of the antitrust laws. But the Fifth Circuit held that the arrangements involved in this case do not constitute the "business of insurance" and, thus, are *never* exempted from the antitrust laws. This holding is contrary to all prior decisions on the point. It substitutes, for the certainty required to establish effective risk protection and cost control, the vagaries of case-by-case antitrust litigation. It undermines effective state regulation of the costs of insurance, frustrates the purposes of the McCarran-Ferguson Act, and upsets a well-established and increasingly necessary means by which companies can provide their employees with adequate health protection.

ARGUMENT

Introduction

In 1945, in response to this Court's decision in *United States* v. *South-Eastern Underwriters Association*, 322 U.S. 533 (1944), Congress enacted the McCarran-Ferguson Act, which exempted the "business of insurance" from application of the antitrust laws, where that business is regulated by state law.[4] In *SEC* v. *National Securities, Inc.*, 393 U.S. 453 (1969), the Court considered the scope of this "business of insurance" exemption. While recognizing that the Act did not purport to exempt "all the activities of insurance *companies*," *id.* at 459 (original emphasis), the Court recognized that activities dealing with control over "the relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement" —specifically including rate regulation—were at the core of the business of insurance.[5]

The contractual arrangements at issue in this case not only affect the specific terms and type of insurance available but also are vital to the provision of health insurance at reasonable rates. They are thus central to the "business of insurance."

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[4] 15 U.S.C. §§ 1011-15 (1970). The exemption does not apply to "any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation." 15 U.S.C. § 1013(b).

[5] 393 U.S. at 460.

I. Contractual Arrangements with Providers of Health Care Are Central to the Relationship Between Insurer and Insured.

A. *Such Arrangements Are a Traditional Form of Health Insurance.*

Prepaid insurance protection, which requires contractual arrangements with providers of health care, has been a traditional form of health insurance. As is pointed out by *amicus* National Association of Insurance Commissioners, Blue Cross/Blue Shield has offered prepaid protection of this sort since its inception in 1939. Such arrangements have been subject to regulation by state insurance departments since that time.[6] Member com-

[6] *See* 1939 N.Y. Laws (Insurance) § 254 (codified at N.Y. Insurance Law (McKinney 1966) § 254). The traditional use of such contractual arrangements in the health insurance business was forcefully called to Congress's attention at the time it considered the legislation which subsequently became the McCarran-Ferguson Act. Attorney General Biddle, testifying in opposition to the Act, indicated that he had authorized the bringing of *South-Eastern Underwriters* because of his belief that the Supreme Court's then-recent decision in *American Medical Assn.* v. *United States*, 317 U.S. 519 (1943), subjected the business of insurance to the antitrust laws. In doing so, he aptly characterized health prepayment plans, with attendant provider contracts, as the essence of the insurance business:

> "Since the decision of the Supreme Court in *American Medical Association* v. *United States* . . . , it is manifest that insurance is trade or commerce—remember, that was the question in these cases following *Paul* v. *Virginia*—within the provisions of section 3 of the Sherman Act. That case involved a conspiracy against Group Health, in its essence indistinguishable from insurance although not formally so termed. The court said:
>
> > 'Group health is a membership corporation engaged in business or trade. *Its corporate activity is the consummation of the cooperative effort of its members to obtain for themselves and their families, medical service and hospitalization on a risk-sharing prepayment basis.*'

[Footnote continued on page 7]

panies of MVMA have purchased such protection for their employees at least since 1950, when they entered into collective bargaining agreements with the UAW providing for such benefits.

As the Brief for Petitioners demonstrates in detail, these arrangements have been uniformly considered to be part of the "business of insurance" by each circuit and district court that has considered the question, until the decision of the Fifth Circuit in this case. Although the decision below concerns directly only contracts between insurers and pharmacies, it threatens the historical use of such contracts across the entire spectrum of health insurance.

B. *The Arrangements Are Called for by the Contract of Insurance, and Provide Distinct Risk Protection to the Insured.*

Under the agreements at issue in this case, various "participating pharmacies" accept an insurance policy's deductible amount as full payment from the insured for covered drugs, and look to the insurer (Petitioner Blue Shield) for reimbursement for the remainder of their charge. The Fifth Circuit held that such agreements were not related to the insurer's obligation to its insureds, and thus did not constitute "the business of insurance." In the Fifth Circuit's view, the agreements

[6] [Continued]

> *"This definition fits but one word, and that perfectly. The word is 'insurance.'* Continuing, the court said:
>
> > 'The corporation collects its funds from members. *With these funds physicians are employed and hospitalization procured on behalf of members and their dependents.* The fact that it is cooperative and procures service and facilities on behalf of its members only, does not remove its activities from the sphere of business.' "

Joint Hearings Before the Subcommittees of the House and Senate Committees on the Judiciary on S.1362, H.R.3269 and H.R.3270, 78th Cong., 1st Sess., 41-42 (1943) (emphasis added).

were designed for the sole purpose of strengthening the financial condition of the insurer "by minimizing costs and maximizing profits." (App. 126a.)

But the Fifth Circuit ignored the fact that the insurance policy itself—the "contract of insurance"—by its terms obligates the insurer to contract with participating pharmacies to secure these particular arrangements.[7] Substantially identical provisions appear throughout prescription drug insurance plans purchased by MVMA's member companies for their employees. Provisions requiring arrangements with providers appear in the members' plans providing, *inter alia*, hospitalization, medical care, vision care, dental care and hearing aid benefits. The companies purchase such coverage not only from Blue Cross/Blue Shield, but also from a number of other insurance carriers.[8]

Such provisions meet the specific insurance needs of the insured employees and their employers. The nature of the protection afforded an insured by these provisions can best be seen from the existing alternative in the present case—the risks and inconvenience of dealing with a non-participating provider. When the insured purchases drugs from a non-participating pharmacy, he must pay the entire amount charged by the pharmacy and subsequently seek reimbursement from the insurer. Moreover, the insurer will only reimburse the insured for a fixed percentage of his expenses in excess of the plan's deductible amount.[9] Thus, the employee is uninsured for a portion of the amount charged. There is no ceiling on these potential uninsured expenses, since there is no limit

[7] *See* App. 57a.

[8] Carriers providing such coverage include, *inter alia*, Aetna Life and Casualty Insurance Company, John Hancock Mutual Life Insurance Company, Lincoln National Life Insurance Company, and Metropolitan Life Insurance Company.

[9] *See* App. 57a.

on his potential need for various drugs. In addition, the insurer's agreement to reimburse the insured for a portion of the *usual and customary* charge for a particular drug in excess of the deductible amount leaves the insured liable for *100%* of any charges in excess of what is usual and customary. Thus, the insured is vulnerable to overcharging by a pharmacist.

The risks of unlimited expenses and overcharging by hospitals, doctors and other providers of health care are particularly acute throughout the health field. First, the insured's need for health services is often immediate and crucial. Second, that need is not determined by the patient himself.[10] Third, comparative price information is limited. For these reasons, protection against these risks is of particular value to insureds in the health insurance area.

Policy provisions for contractual arrangements between the insurer and the provider of health care clearly protect the insured against both the risk of having to bear a portion of his potential medical expenses and the risk of overcharging. The availability of "participating" pharmacies, physicians and other providers essentially protects the insured against *any* cost in excess of the deductible amount—protection which he might not otherwise be able to obtain at all, and which he certainly could not obtain at a comparable cost.[11] As this Court has noted, the "underwriting of risks" is the essence of the business of insurance. *See SEC* v. *Variable Annuity*

[10] "The physician's diagnosis determines the extent to which his or her own services are required as well as the utilization of diagnostic tests, therapeutic drugs, and hospitals. The patient usually lacks sufficient information or expertise, even if so inclined, to question a physician's recommendation or to seek possible alternatives." Council on Wage and Price Stability, *The Complex Puzzle of Rising Health Care Costs: Can the Private Sector Fit It Together?* 85 (1976) (hereinafter cited as "CWPS").

[11] *See* Part II.A., *infra*.

Life Insurance Co., 359 U.S. 65, 73 (1959). The provision at issue provides distinct additional risk protection to the insured, and is central to the insurer-insured relationship.

C. *The Contractual Arrangements Reflect the Expressed Desires of the Insured.*

The insurer's obligation to contract with providers of health goods and services confers a distinct benefit of considerable value and importance to insureds and their employers, and they have specifically sought such provisions.[12]

This is demonstrated by the experience of the member companies of MVMA. Group health benefits, like most other elements of the employer-employee relationships common to MVMA members, have long been part of the collective bargaining process between companies and the unions representing their employees. Specific provisions regarding prescription drugs have been included, at the unions' insistence, in the companies' collective bargaining agreements for more than a decade. The United Auto Workers demanded prescription drug coverage in contract negotiations at least as early as 1964, and specific prescription drug benefits were actually agreed upon for the first time by the UAW and Ford in 1967.

In bargaining for a drug insurance plan, the company and the union negotiated the terms of each element of the proposed plan. The type of drugs covered, methods of benefit payment, controls to limit premium costs, and various exclusions were all negotiated and incorporated in the final contract between the parties. The specific question of whether the plan should include contractual

[12] Approximately 80% of health insurance premiums are paid through employment-related group insurance plans such as those maintained by MVMA's member companies for their employees. (*See* CWPS at 84.) In these plans, the employees are the insureds, but the employer pays all or part of the premiums.

arrangements between the insurer and "participating pharmacies," or should instead provide for reimbursement of the insured employees for a portion of "usual and customary" charges, regardless of the pharmacy chosen, was also negotiated. While the parties recognized certain other advantages and disadvantages to each method of payment, the extra protection of the "participating pharmacy" plan was agreed to and made a part of the collective bargaining agreement.

The resulting agreement, which became standard in the motor vehicle industry, provided that the companies would make arrangements with insurance carriers to provide prescription drug expense benefits, with a deductible amount of two dollars for each separate prescription order and refill, under which "Participating Providers" would accept a two dollar payment from the insured employees, and be reimbursed by the insurer for its acquisition cost plus a dispensing fee. Insured employees obtaining drugs from a non-participating provider would be reimbursed for 75% of the pharmacy's "usual and customary charges" in excess of the deductible amount.

These provisions for arrangements with pharmacies, worked out in the collective bargaining process, were incorporated into the contracts of insurance. This history is neither unique to the particular prescription drug provisions at issue in this case, nor to the auto industry. As a result of the collective bargaining process, similar provisions require contractual arrangements in hospitalization, vision care, dental care, and hearing aid plans purchased by MVMA's members. Employees in other industries have also sought out, through the collective bargaining process, a wide variety of prospective reimbursement programs in all areas of health benefits.[13] The fact that

[13] For example, the United Federation of Teachers contracts with pharmacists and providers of optical care, and its insurers contract with "participating" dentists to provide its members with benefits

the insured employees—and the employers bearing all or part of the cost of the plans—have themselves specifically demanded provisions for arrangements between carriers and health providers demonstrates that such arrangements are central to the insured-insurer relationship and, thus, to the "business of insurance." The court below was simply wrong in concluding that Blue Shield's contractual agreements with "participating pharmacies" were of no concern to the insureds or their employers.

II. The Cost-Containment Function Performed by Contractual Arrangements with Providers of Health Care Is a Vital Part of the "Business of Insurance."

As Judge McGowan, writing for the United States Court of Appeals for the District of Columbia Circuit, has emphasized, the very fact that particular activities and methods of reimbursing insureds directly and substantially affect the cost of a particular level of insurance protection constitutes a "persuasive indication that the activities are part of the business of insurance":

> "Of central significance in this entire context is the close relationship between the cost of reimbursing damage claims, on the one hand, and the insurance rates charged by appellees, on the other. Any doubt as to whether these activities should be deemed to fall within the business of insurance is ponderably eased by that economic reality." *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, 561 F.2d 262, 268-69 (D.C. Cir. 1977), *petition for cert. filed*, 46 U.S.L.W. 3375 (U.S. Dec. 6, 1977) (No. 77-580) (footnote omitted).

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similar to those negotiated in the motor vehicle industry. Similar coverage is provided to, *inter alia*, steelworkers, mineworkers and retail clerks. *See generally* Council on Wage and Price Stability, *Labor-Management Innovations in Controlling Cost of Employee Health Care Benefits*, 41 Fed. Reg. 40297 (Sept. 17, 1976) (reprinted in CWPS at 97).

Contractual arrangements such as those at issue in this case not only directly affect insurance rates, but are critical to making health insurance available at affordable rates.

A. *Contractual Arrangements with Providers Are Vital to Cost Containment in Health Insurance.*

The validity of the "economic reality" described by Judge McGowan—that rates are affected by the costs of reimbursement—is reinforced in the case of health insurance by a second economic phenomenon. The pervasiveness of health insurance in our society itself increases the costs of health goods and services, and, hence, the costs of reimbursement:

> "Rising health care costs, often propelled by excessive utilization of facilities and by a tendency to overinvest in high-technology equipment, have in many cases not been translated directly into higher prices for the consumer. Most patients have some form of insurance which lessens the burden of comparing the value of care with its price. Rising costs simply get translated into higher premiums in subsequent years, but not into prices confronting the consumer at the point of purchase of health care services. In addition, many providers are reimbursed by insurers on a retrospective basis, thus providing little incentive for efficiency in managing scarce resources." [14]

This phenomenon has intensified the crisis of rising costs of medical care. In these circumstances, the insurer must either pass on spiraling costs to policyholders, or he must find some way of minimizing the costs of the insured services through arrangements with providers. Insurance premiums have already reached excessive levels, and insurance carriers and employers have sought to

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[14] CWPS at 10.

control excessive use of insured services by imposing a percentage of the costs for the services used on the insured employees.[15] Coinsurance of this type is included in the plan at issue in this case as an alternative method of cost containment where drugs are purchased from a non-participating pharmacy.[16] Another method of discouraging excessive use of services, adopted in some policies, is to exclude from coverage "some ancillary services which may be highly elective, 'such as cosmetic surgery, dental and optical care.'" [17]

However, unions, in negotiating health benefits, have resisted plans which require coinsurance or other cost-sharing procedures.[18] Moreover, while coinsurance is useful in discouraging excessive and unnecessary use of health services, many health services are not "elective." Demand for such essential health services is inelastic, and coinsurance can only control the escalating costs of these services to a limited degree. For these reasons, both companies and unions have sought alternative means to contain rising costs.

The most effective alternative to restricting or discouraging the use of insured goods and services is instituting cost-containment measures which affect providers of medical services. That is the general course which has been taken in the auto industry. Thus, the health insurance benefits agreements negotiated between MVMA's

[15] As the Council on Wage and Price Stability reported, in summarizing hearings on the problem of rising health care costs, "Several companies indicated they would retain deductibles and coinsurance in their health benefit program in order to provide consumer incentives not to overutilize services." CWPS at 26.

[16] *See* pp. 8-9, *supra.*

[17] CWPS at 26.

[18] "Testimony from union officials indicated almost unanimous opposition to the reintroduction of copayment in health benefit plans." *Id.*

members and the UAW require the carriers to take extensive measures to control the cost of health services provided. The carriers are required, in addition to contracting with providers, to take numerous cost-control steps which directly affect providers. Such measures include pretreatment estimates of fees, peer reviews, price reviews, post-treatment evaluations, and utilization reviews.

As the Council on Wage and Price Stability's report on rising health care costs makes clear, all of these measures are used in various combinations virtually throughout the insurance industry, and are demanded by insured employees and their employers, in order to contain costs.[19] But, as the Council found, because such measures are dependent upon the voluntary cooperation of providers—in most cases, after the service has been provided—they are not nearly as effective as direct, contractual arrangements between insurers and providers in controlling medical costs.[20] Therefore, employers and employees in the auto industry have insisted on provisions for such arrangements in their health insurance plans.

It is, no doubt, for similar reasons that the federal government, in the programs where it serves as a health insurer, relies extensively on contractual arrangements with providers of health care. For example, Medicare regulations prohibit participating providers from charging Medicare customers an amount greater than an established reimbursable fee.[21] Similarly, participation in

[19] *See* CWPS at 23-31.

[20] "Several witnesses at the hearings testified that their efforts to increase involvement in cost control programs, even where they were just requests for information, were met by provider resistance." *Id.* at 24. On the other hand, the Council found that contractual arrangements can significantly reduce the costs of prescription drugs. *Id.* at 119.

[21] *See* 20 C.F.R. § 405.433(a)(4) (1977).

Medicaid is "limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure." [22] And the government's military dependent health insurance regulations provide for contractual arrangements with participating pharmacies, which must agree to accept the "actual acquisition cost of ingredients plus an established professional fee" as full payment from the insured.[23]

The contractual arrangements at issue in this case were implemented by the carriers to meet the health care cost crisis head-on. Such cost-containment arrangements and mechanisms are essential to controlling spiraling health care costs, which otherwise would result in constantly increasing insurance premiums or direct charges to the insured. This direct and significant interrelationship with the cost of insurance makes such arrangements central to the interests determined by Congress to be reserved for state regulation of the "business of insurance."

B. *Cost Control Is Part of the "Business of Insurance" for Which State Regulation Is Appropriate.*

By exempting the "business of insurance" from application of the antitrust laws only "to the extent that such business is . . . regulated by State law," [24] Congress obviously did not mean to free the insurance industry from all regulation, on the premise that the political and economic theories embodied in the antitrust laws do not apply to the business of insurance. Rather, Congress recognized that the business of insurance has a special impact on the public, and that specific policy concerns embodied in state regulation may supersede the more general policies of the antitrust laws in this sector of the economy.

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[22] *See* 45 C.F.R. § 250.30(a)(8) (1976).

[23] *See* 32 C.F.R. § 577.64(a)(4) and (h)(4) (1977).

[24] 15 U.S.C. § 1012(b) (1970).

In enacting the McCarran-Ferguson Act, Congress specifically recognized the validity of this Court's holding in *Osborn* v. *Ozlin*, 310 U.S. 53 (1940), that the states must be permitted to regulate insurance effectively.[25] As Mr. Justice Frankfurter noted:

> "Government has always had a special relation to insurance. The ways of safeguarding against the untoward manifestations of nature and other vicissitudes of life have long been withdrawn from the benefits and caprices of free competition." 310 U.S. at 65.

Congress clearly saw that effective regulation of insurance could conflict with antitrust policies, and opted for effective regulation.[26]

This Court made clear, in *SEC* v. *National Securities, Inc.*, *supra*, that among the policy interests which may, if embodied in state regulation, supersede the antitrust laws are not only the protection of the insurance companies' viability, but also—and primarily—"the interests of those purchasing insurance policies." [27] Congress clearly recognized that an important task of state regulation of

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[25] *See* S. Rep. No. 1112, 78th Cong., 2d Sess. 6 (1944); H.R. Rep. No. 873, 78th Cong., 1st Sess. 8 (1943).

[26] As one commentator has noted,

> "Except for boycott, coercion, and intimidation, any act repugnant to the federal antitrust laws may be authorized by the state so long as public regulation is provided. This is a basic fact which should not be avoided apologetically as something vaguely wrong; it should be publicly stressed again and again, so that all may understand that every legislative body in the United States has determined that it is not in the public interest to have the Sherman Act apply to the business of insurance in the unqualified manner in which it affects the ordinary industry." Donovan, *Regulation of Insurance Under the McCarran Act*, 15 L. & Contemp. Prob. 473, 490 (1950).

[27] 393 U.S. at 460. Congress specifically intended that states enact regulatory schemes which would "consider the welfare of policyholders." H.R. Rep. No. 143, 79th Cong., 1st Sess. 4 (1945).

insurance was "preventing excessive charges to the public." [28]

Arrangements between insurers and providers of health care play a crucial role in preventing excessive rates. Contracts between insurers and providers are already subject to regulation in a large number of states, and state officials are increasingly focusing on such arrangements as a means of cost containment.[29] The former Insurance Commissioner of Pennsylvania has, in fact, testified that it is *impossible* to assure adequate health insurance coverage at a reasonable cost without such regulation:

> "[W]e think that these two items, the contract with the hospitals and the rates to the subscribers are part of the same package *and we have to regulate both of them together* or that we cannot provide health delivery to the public at the most reasonable cost possible." [30]

Indeed, the states are increasingly turning to *direct* regulation of the rates charged by providers of health services, and "[s]everal states have initiated hospital rate regulation . . . ." [31]

Arrangements with health care providers such as those involved here are consistent with the antitrust laws. Even if they were not, the state's interest in facilitating and regulating them would be thwarted by subjecting

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[28] 90 Cong. Rec. 6527 (1944) (remarks of Rep. Miller).

[29] *See* Brief for National Association of Insurance Commissioners for a comprehensive discussion of the present scope and nature of such state regulation. In the present case, the District Court specifically found that "[t]he State of Texas has actively regulated the activities challenged in Plaintiff's Complaint since the inception of Blue Shield's prescription drug insurance program." (App. 109a.)

[30] Cited in *Travelers Ins. Co.* v. *Blue Cross*, 481 F.2d 80, 83 n.9 (3d Cir. 1973) (emphasis added).

[31] CWPS at 39.

them to antitrust challenges. Contractual arrangements substantially the same as those at issue in this case have, on several occasions, received business review clearance by the Department of Justice.[32] Yet, as in this case, private parties have nevertheless subjected persons attempting to implement these cost-control measures to the uncertainties, expenses and delays of private antitrust litigation. The threat of such litigation not only delays implementation of wholly legal and desirable arrangements, but may effectively deter their future development and improvement, notwithstanding the expressed interest of the states in such programs and the benefits they provide to the public. To subject each cost-containment innovation involving providers of health care to *ad hoc*, case-by-case examination—with potentially different results in different courts—would make meaningful regulation of health insurance difficult, if not impossible.

Congress meant to exempt from the antitrust laws those insurance practices which are subject to state regulation in the public interest. That exemption does not apply to coercion, boycott or intimidation. Beyond this, however, the public policy issue has been determined. The availability of health insurance coverage at reasonable rates is intimately a part of the business of insurance. If there is a conflict with antitrust policy, Congress has decided that the interest of the public in regulation of health care insurance should prevail. The Fifth Circuit's decision contravenes that interest. It interferes with the ability of the states to control rates and types of coverage. It will produce higher premiums and reduced risk protection. Congress, in exempting "the business of insurance" from the antitrust laws, did not and could not have intended such a result.

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[32] *See, e.g.*, Letter from Assistant Att'y Gen. Donald F. Turner to Gerald L. Goodell, Esq. (Jan. 15, 1968), reproduced as Appendix C to Amicus Curiae Brief of Blue Shield Association in support of petition for certiorari.

CONCLUSION

For the reasons stated above, the decision below should be reversed.

Respectfully submitted,

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In the Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

Brief of the Participants in the Kaiser-Permanente Medical Care Program as *Amici Curiae*

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United States Supreme Court Rules, Rule 42 1

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Brief of the Participants in the Kaiser-Permanente Medical Care Program as *Amici Curiae*

This brief is filed on behalf of the Kaiser-Permanente Medical Care Program (the "Program"),[1] with the written consent of all parties to this proceeding pursuant to Rule 42 of the Court.

1. The specific entities which together constitute the Program are: Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Oregon, Kaiser Foundation Health Plan of Colorado, Kaiser Community Health Foundation, Kaiser Foundation Hospitals, The Permanente Medical Group, Southern California Permanente Medical Group, Northwest Permanente, P.C./Physicians & Surgeons, Colorado Permanente Medical Group, Ohio Permanente Medical Group, Hawaii Permanente Medical Group, Inc., Permanente Services, Inc., Southern Permanente Services, Inc., Permanente Services of Oregon, Inc., Permanente Services of Hawaii, Inc., Permanente Services of Colorado, Inc., and Ohio Permanente Services, Inc.

NATURE OF THE INTEREST OF AMICI CURIAE

The Program is a nonprofit, prepaid health care insurance system that serves over three million enrolled members in six geographical regions. The Program is a prototype Health Maintenance Organization ("HMO"). As such it arranges and provides to its members comprehensive, prepaid health care at Program facilities. Covered services include hospital, physician, pharmaceutical and related health services. The Program has been formally qualified under the Health Maintenance Organization Act of 1973 ("HMO Act"), 42 U.S.C. § 300e, *et seq.*[2]

Several of the Program organizations were sued in cases currently on appeal from the United States District Court for the Central District of California to the Court of Appeals for the Ninth Circuit (the "PRDA cases").[3] The PRDA cases were ostensibly filed on behalf of all retail drug stores in the states of California, Washington and Oregon, and allege that the Program organizations have violated certain federal antitrust laws, specifically Section 2(f) of the Robinson-Patman Act, 15 U.S.C. § 13(f), and Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2,

2. Under the HMO Act, an "HMO" is technically an organization that accepts contractual responsibility to arrange health services in return for premium payments. Some HMOs directly employ physicians and own hospitals, but many do not. The term "HMO" is perhaps more commonly used to identify not only the enrollment organization, but also the related physicians, hospitals and other health care providers that operate as components of an integrated health care delivery system, even though they may represent legally separate organizations. We use the term in this broader sense.

3. The cases are *Portland Retail Druggists Ass'n, Inc. v. Kaiser Foundation Health Plan,* (Civil No. 77 1485-IH) and *DeModena v. Kaiser Foundation Health Plan,* (Civil No. 77 0005-IH). Some of the sales in question are the subject of an action by retail pharmacists against drug manufacturers and were considered by the Court in *Abbott Laboratories v. Portland Retail Druggists Ass'n, Inc.,* 425 U.S. 1 (1976).

by (1) knowingly inducing or receiving discriminatorily low prices for drug products, (2) attempting to monopolize the retail drug market, and (3) "tying" the sale of prescription drugs to the sale of other prepaid health care services. Summary judgment was entered in favor of the Program organizations (1) as to all claims on the grounds that the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, withdraws the Program from regulation under the federal antitrust laws, (2) as to the Robinson-Patman Act claims on the grounds that the Program is entitled to the protection of the Nonprofit Institutions Act, 15 U.S.C. § 13c, and (3) as to the Sherman Act claims on the basis that there was a lack of predatory conduct or specific intent to monopolize, that no illegal tying exists, and that plaintiffs failed to state a claim upon which relief could be granted.

While there are significant differences between the form of organization and method of operation of the Program and that of the Blue Shield petitioners in this case, the position taken by the Court with respect to the exemption afforded by the McCarran-Ferguson Act may have considerable impact on the services provided by HMOs, like the Program, and may have relevance to the issues on appeal to the Ninth Circuit in the PRDA cases. For these reasons, and as elaborated upon hereinafter, *amici curiae* are vitally interested in the issues presented to the Court for its decision.

ARGUMENT

Congressional Policy Promoting HMOs Should Not Be Curtailed by a Narrow Interpretation of the McCarran-Ferguson Act.

The inability of the traditional fee-for-service sector of the health care economy to provide quality health care services at a reasonable cost has stimulated Congressional encouragement to establish and expand alternate forms of

health care delivery systems. The staggering increases in health care costs over the last decade have been documented by a host of authorities. In setting forth its report on the proposed HMO Act, the Senate noted that national health expenditures rose by 188 percent in the eleven year period from 1960 to 1971. S. Rep. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* [1973] *U.S. Code Cong. & Ad. News,* 3033. The Senate Report indicated that a large portion of the cost increases went to meet the "continuing inflation" of health care prices and "to subsidize inefficiency and waste in the delivery of health care services." *Id.* Further, the traditional health care "system" was seen as relatively indifferent to preventive care and the early treatment of disease and as relying on costly and intensive hospital care when treatment was finally sought. *Id.*

The federal government has been involved with issues relating to rising health care costs both in its role as a regulator and in its role as a purchaser of health care services. During the past several decades, government has become a principal purchaser of health care services.[4] As a purchaser of health care services, the government has been hit by rising costs and recent legislation evidences an increasing concern with the cost of such purchases.[5]

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4. Prior to Medicare and Medicaid, government at all levels paid about 24% of the national health bill. Today it pays 42%. Since 1965, health expenditures as a percent of the gross national product have increased from 5.9% to 8.6%. Gibson, Robert M., and Mueller, Marjorie Smith, "National Health Expenditures, Fiscal Year 1976," *Social Security Bulletin,* Social Security Administration, DHEW 40 (4), Table 1 at 4 (April, 1977). It was estimated that during 1977 the federal government would infuse about $46 billion into the private health care sector.

5. This concern has been manifested through (a) requirements for reviewing the need for continued hospitalization of patients covered under Medicare and Medicaid, 42 U.S.C. § 1320c; (b) restrictions on expansion of health care facilities and services, 42 U.S.C. § 1320a-1; (c) fraud squads to catch Medicaid cheats, 42 U.S.C. § 3521-3527; and (d) the Administration's current proposals to limit increases in hospital's annual income to 9% and to impose a national limit on new capital expenditures for acute care hospitals, Hospital Cost Containment Act of 1977, S. 1391 and H.R. 6575, 95th Cong., 1st Sess.

In addition to direct efforts to cut federal expenditures for health care, Congress also has sought to encourage development of alternative health care delivery systems which are considered to have potential for reducing inflation in health care costs. These efforts are seen not only as a way to lessen the government's financial burden as a health care purchaser, but also as a way to reduce expenditures by the consuming public. Congress found that HMOs have an inherent cost efficient tendency. S. Rep. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* [1973] *U.S. Code Cong. & Ad. News,* 3033, 3034. In discussing the benefits to be provided through the HMO form of organization, the Senate Report stated:

> The fixed price concept for comprehensive services provides a strong financial incentive to physicians, hospitals and other institutional providers of health care services to place greater emphasis on preventive services to avoid the need for costly, intensive care which can reduce their income. At the same time, HMO's are motivated to function more efficiently since the cost of wasteful and inefficient practices cannot be passed on to the consumer or to third party payers. *Id.*

In addition, the HMO was seen by Congress as organizing medical resources in a convenient and responsive manner and as providing substantial economic and professional advantages to participating physicians. *Id.* at 3034 and 3041.

The ability of HMOs, such as the Program, to provide high quality care at low cost has been recognized in studies by universities, government agencies, commissions engaged in research, and other research organizations. The Report

of the National Advisory Commission on Health Manpower, for example, concluded that "the cost to the average person who obtains medical care through Kaiser is 20-30 percent less than it would be if he obtained it outside." II *National Advisory Commission On Health Manpower, Report* (1967) 206-7. Results of other studies indicating the lower total health care costs of Program members are summarized in Exhibit 1 hereto. Cost savings of HMOs, such as the Program, are in part obtained through lower hospital utilization. These savings are primarily a result of the Program's comprehensive benefit structure that emphasizes ambulatory care for its members, combined with economic incentives that encourage physicians to use the most appropriate, not the most expensive, method of treatment. Exhibits 2-4 hereto illustrate the considerable savings in hospitalization that the Program has achieved.

In response to substantial evidence presented to it concerning the savings provided by HMOs and the benefits to society to be obtained through them, Congress adopted the HMO Act as a means of encouraging and regulating the development of the HMO.[6] As structured by the HMO Act,

6. HMOs are also subject to extensive regulation under state law. Illustrative of the types of regulations that have been enacted by the states which are applicable to HMOs are the following laws of the states of California, Oregon and Washington which, *inter alia*, require the licensing of health plans, Cal. Health & Safety Code §§ 1340-1399.5; regulate the financial capability and responsibility of health plans, Cal. Health & Safety Code §§ 1342(d) and 1372(1), Or. Rev. Stat. § 731.574, Wash. Rev. Code § 48.44.160(2); and regulate a plan's contracts with its members and the providers of services, Cal. Health & Safety Code § 1367(h), Or. Rev. Stat. § 731.012, Wash. Rev. Code §§ 48.44.010(4), 48.44.020(2), and 48.44.070. Further, some state laws regulating HMOs also make specific reference to laws relating to unfair business practices and unfair competition or provide for sanctions and disciplinary actions for violation thereof. Cal. Health & Safety Code §§ 1386(a), (b)(7) and (9) and Or. Rev. Stat. §§ 731.418(b), 731.988, and 731.992.

an HMO in effect provides a new kind of insurance in the health care area. To qualify under the HMO Act, an HMO must provide the health care services directly, not simply reimburse the insured for services he obtains from other health care providers. The Act requires HMOs to have a fiscally sound operation and to "assume full financial risk on a prospective basis for the provision of basic health services," subject to an ability to obtain reinsurance or to take other measures to offset only a portion of the cost. 42 U.S.C. § 300e(c)(1) and (2); *see also,* S. Rep. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* [1973] *U.S. Code Cong. & Ad. News,* 3033, 3045-6.

The HMO Act institutionalizes a number of structural requirements designed to insure that HMOs act in consumers' best interests. First, the HMO Act requires HMOs to establish their rates under a "community rating" method under which all enrollees pay the same rate for the same contract benefits, and does not permit "rating up" based on actual utilization of health care services. With community rating, groups whose members include those least able to afford health insurance, *e.g.,* the aged and chronically ill, can obtain HMO coverage at the same cost as other subscribers. 42 U.S.C. § 300e(b)(1)(C), *see also,* S. Rep. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* [1973] *U.S. Code Cong. & Ad. News,* 3033, 3061. Second, the HMO Act requires that financially stable HMOs have annual open enrollment periods during which they must accept all applicants without regard to their previous health history. 42 U.S.C. § 300e(c)(4) and (d), *see also,* S. Rep. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* [1973] *U.S. Code Cong. & Ad. News,* 3033, 3061. In addition, HMO enrollees must have a substantial representation on the HMO's governing body. 42 U.S.C. § 300e(c)(6).

As originally enacted, the HMO Act recognized "basic" health services, which the HMO was required to include as covered benefits for all enrollees, and "supplemental" health services, which the HMO was required to make available as optional benefits. The basic health services included physician services, inpatient and outpatient hospital services, medically necessary emergency health services, diagnostic laboratory services and other related services. Outpatient prescription drugs were included as a supplemental benefit. 42 U.S.C. § 300e-1(1) and (2).

The importance of HMOs' providing drugs as part of their comprehensive health care system was described in the Senate Report on the HMO Act:

> . . . each HMO must provide prescription drugs either directly or through arrangements with others. It is intended that this requirement will result in the rational use of the appropriate and most efficient prescription drug preparation in a particular situation. In providing drug services, the Committee expects that the HMO will establish patterns of patient-drug utilization, and will utilize the services of clinical pharmacologists, or pharmacists qualified to evaluate the appropriateness of drug usage within the HMO.
>
> The requirement that a clinical pharmacist survey, evaluate, and review patterns of patient drug utilization (including drug regimens and therapies) and maintain a drug use profile for each enrollee of an HMO is intended to ensure the input of a drug specialist into the development of a rational drug therapy for each patient. The Committee expects such a pharmacist to be one who has had substantial training and experience in designing and monitoring patient drug therapy.
>
> In addition, the clinical pharmacist is expected to play a major role in disseminating important drug use and abuse information, both to the HMO staff and the

> member patients. (S. Rep. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* [1973] *U.S. Code Cong. & Ad. News,* 3033, 3042-43.)

In an effort to make the HMO benefit structure more flexible, the mandatory service requirement was relaxed in regard to drugs and a number of other health services by the 1976 amendments to the HMO Act. Nevertheless, supplemental benefits, including pharmaceuticals, are still considered important. The House Report commented concerning the import of the 1976 amendments: "While these amendments will no longer require HMO's to deliver any particular supplemental health service, it is the Committee's hope that, where a group of members desires to contract for a listed service and the necessary health manpower is available, the HMO will make every effort to provide that service." H. Rep. No. 94-518, 94th Cong., 2nd Sess., *reprinted in* [1976] *U.S. Code Cong. & Ad. News,* 4312, 4328. When an HMO contracts to provide a supplemental benefit to its members, the benefit is an integral part of the HMO's overall health care program.

By actually providing their members with health care, HMOs perform a service distinctly different from the predominately financial function (claims paying) of conventional indemnity insurers. With respect to HMOs which purchase drugs and provide them to their members directly, there is an even closer nexus between the insurer and the insured than under Blue Shield-type plans, because the HMO itself is immediately responsible for the availability, cost and quality of care provided. In fact, most Program enrollees are covered under prepaid prescription drug programs.

The HMO Act requires employers to offer a qualified HMO, if one exists in the area, as one of the options avail-

able under their health benefits programs. 42 U.S.C. § 300e-9. The HMO Act thus supports a new source of competition in the health care area and thereby makes an effort to combat rising health care costs in general.

The FTC Staff recently investigated the competitive impact of HMOs on the traditional fee-for-service sector. The summary of the Report states:

> This study tests the hypothesis that the presence of an HMO in an area can have a competitive impact upon the traditional fee-for-service sector . . . The results of the study provide evidence that a significant HMO presence may help lower costs not only to HMO subscribers, but to others in the area, as well. We conclude that the HMO can play a significant economic role in this segment of the health care industry. . . .

Bureau of Economics, *FTC Staff Report on the Health Maintenance Organization and Its Effects on Competition*, vi.

Other existing and proposed federal legislation similarly encourages HMOs. For example, under the Social Security Act, an HMO may elect to be compensated on a basis in which it shares in savings that it realizes in caring for Medicare beneficiaries. 42 U.S.C. § 1395mm. The same legislation authorizes states to provide health services to Medicaid enrollees through prepaid contracts with HMOs. 42 U.S.C. § 1396a(a)(23). Further, under the Administration's proposed Hospital Cost Containment Act of 1977, HMO hospitals would be exempt from the Act's limits on hospital reimbursement and capital expenditures. S. 1391 and H.R. 6575, 95th Cong., 1st Sess.

In short, national policy is to encourage HMO-type programs.

The Congressional objectives in enacting the HMO Act will be jeopardized if HMOs may not observe the Act's

requirements without the overhanging threat of antitrust litigation. As indicated by the PRDA cases, a number of activities necessarily carried on by HMOs might be regarded as subject to attack under the federal antitrust laws absent an exemption. Congress clearly was aware of the existence of the federal antitrust laws when it passed the HMO Act. It must be assumed that it did not intend on the one hand to require or encourage an HMO to engage in certain types of activities and then prohibit those same activities under the federal antitrust laws. The application of the McCarran-Ferguson Act exemption to HMOs brings the federal antitrust laws into harmony with the HMO Act and is consistent with prior interpretations of the scope of the exemption.

In deciding this case, the Court should recognize that any limitation on the scope of McCarran-Ferguson Act exemption may also affect direct health care providers, such as HMOs. In the face of a clear Congressional intent that HMOs be encouraged to provide comprehensive health care, including pharmaceuticals, to their members at reasonable prices, any decision which would restrict the provision of services by HMOs should be carefully evaluated.

CONCLUSION

For the reasons set forth herein, *amici curiae* urge the Court to reverse or expressly limit the decision of the Fifth Circuit in the *Royal Drug* case. Any other result could have vast ramifications with respect to the delivery of health care by HMOs as required under the HMO Act.

DATED: May 12, 1978.

Respectfully submitted,

MAX THELEN, JR.

THELEN, MARRIN, JOHNSON & BRIDGES

Of Counsel

Attorneys for Amici Curiae, Kaiser-Permanente Health Care Program

(Exhibits follow)

Exhibit 1

A UCLA study published in 1975 found the following health care costs for persons enrolled in six prepaid plans, including the Program, in Southern California in 1967:[7]

Health Care Expenses
By Members of Prepayment Plans
Los Angeles County, 1967

Plan	Annual Per Capita Expenses — Out-of-Pocket	Annual Per Capita Expenses — Total
Blue Cross	$108	$235
Blue Shield	$ 74	$230
Large Insurance Company	$ 79	$183
Small Insurance Company	$ 69	$160
Small Group Practice	$ 50	$142
The Program	$ 13	$124

A federal study published in 1975 showed the following average Medicare payments in 1970 for Program members and for member-matched control groups residing in the same area and receiving service under fee-for-service mechanisms:[8]

---

7. Hetherington, Robert W., Hopkins, Carl E., and Roemer, Milton I., *Health Insurance Plans: Promise and Performance,* Table 5-1 at 204 and Table 5-5 at 223 (1975).

8. Corbin, Mildred, and Krute, Aaron, "Some Aspects of Medicare Experience with Group-Practice Prepayment Plans," *Social Security Bulletin,* Social Security Administration, DHEW 38(3), Table 1 at 7 (March 1975).

Exhibit 1 (Continued)

Total Medicare Reimbursement for Health Plan Members Compared to Control Populations, 1970

Program Region	Reimbursement per Beneficiary — Program Members	Control Population	Program Cost Lower By
Southern California	338	414	18%
Northern California	331	406	18%
Oregon	226	337	33%

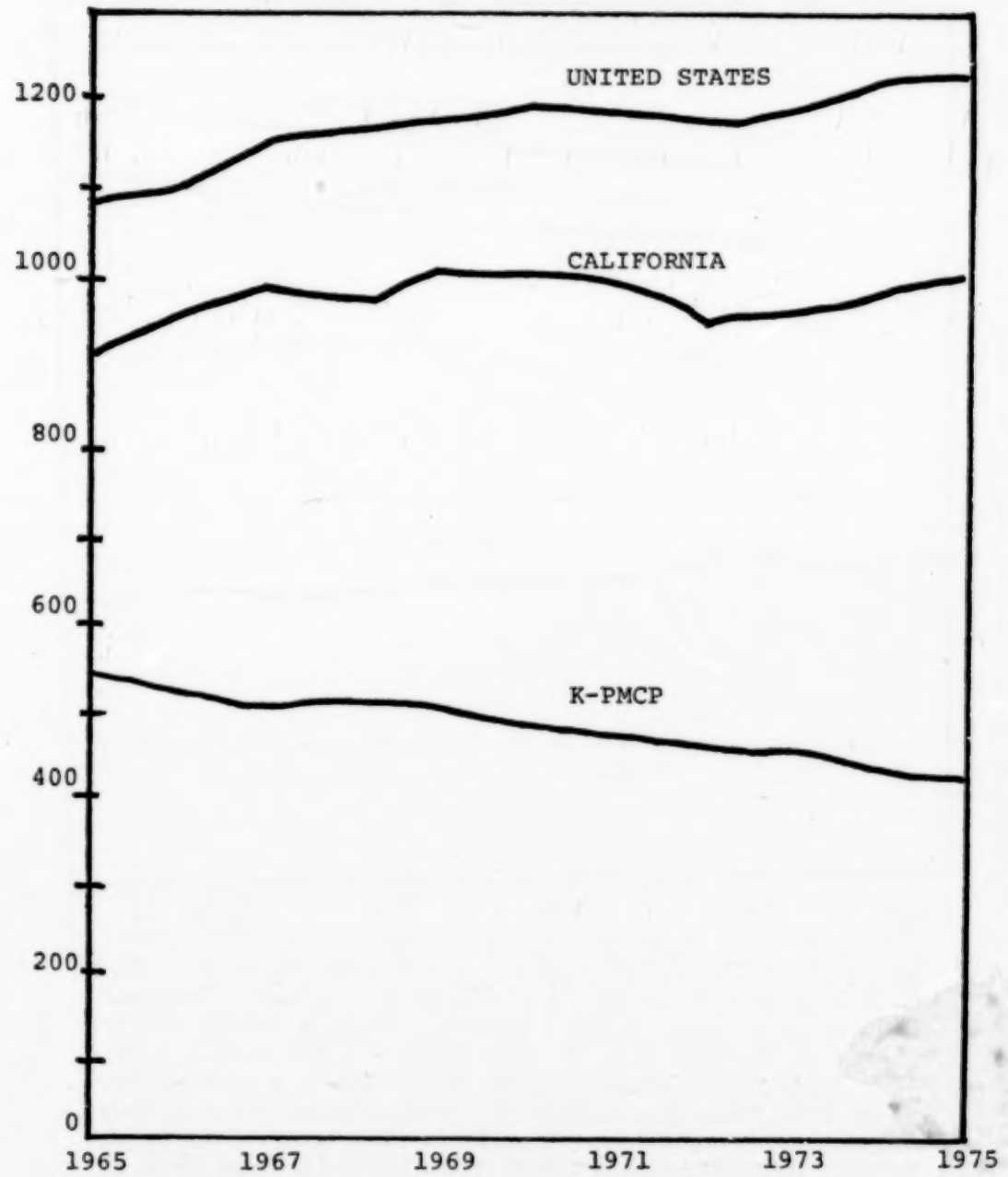
A 1970-71 survey of consumer experience under the State of California employees' Medical and Hospital Care Act showed:[9]

	Kaiser-Permanente: California Regions	State-Wide Service Plans	State-Wide Indemnity Plans	Individual Practice Plans
Average Number of Beneficiaries	89,000	72,000	92,000	5,000
Annual Expenses Per Family				
Total Premiums	$350	$372	$280	$351
Out-of-Pocket Expenses	90	188	203	249
Total Expenses	$440	$560	$483	$600

9. Dozier, Dave, *et al., 1970-71 Survey of Consumer Experience Report of the State of California Employees' Medical and Hospital Care Program* (prepared under the policy direction of the Medical Advisory Council to the Board of Administration of the Public Employees' Retirement System) Table 31 at 99 (May 1973).

Exhibit 2

I. PATIENT DAYS PER 1,000 PERSONS PER YEAR[10]

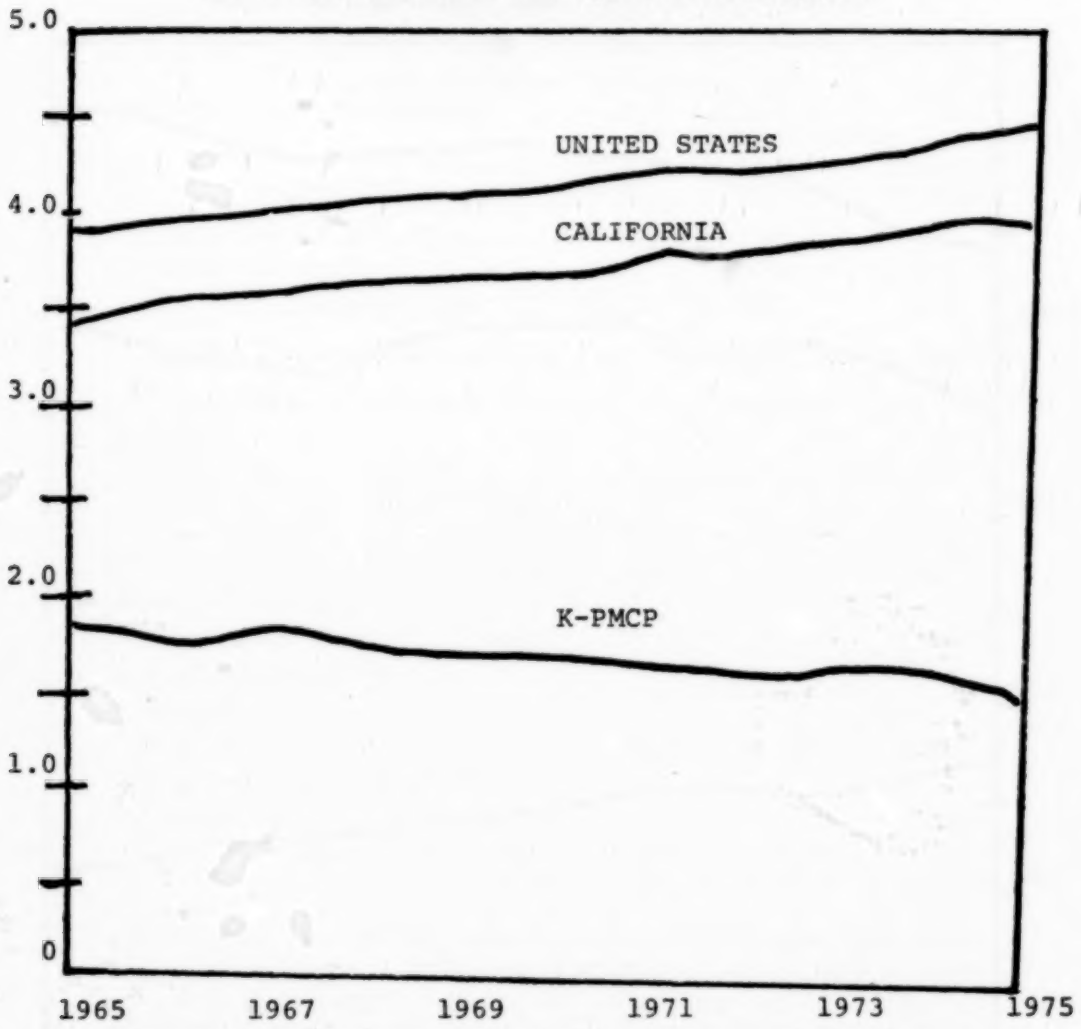


10. United States and California hospital data are from American Hospital Association, *Guide to the Health Care Field, Part 2,* Chicago, Illinois (1965: Table 1, p. 439; Table 3, p. 464; 1966: Table 1, p. 453; Table 3, p. 468; 1967: Table 1, p. 449; Table 3, p.

[continued on next page]

Exhibit 3

II. HOSPITAL BEDS PER 1,000 POPULATION[11]

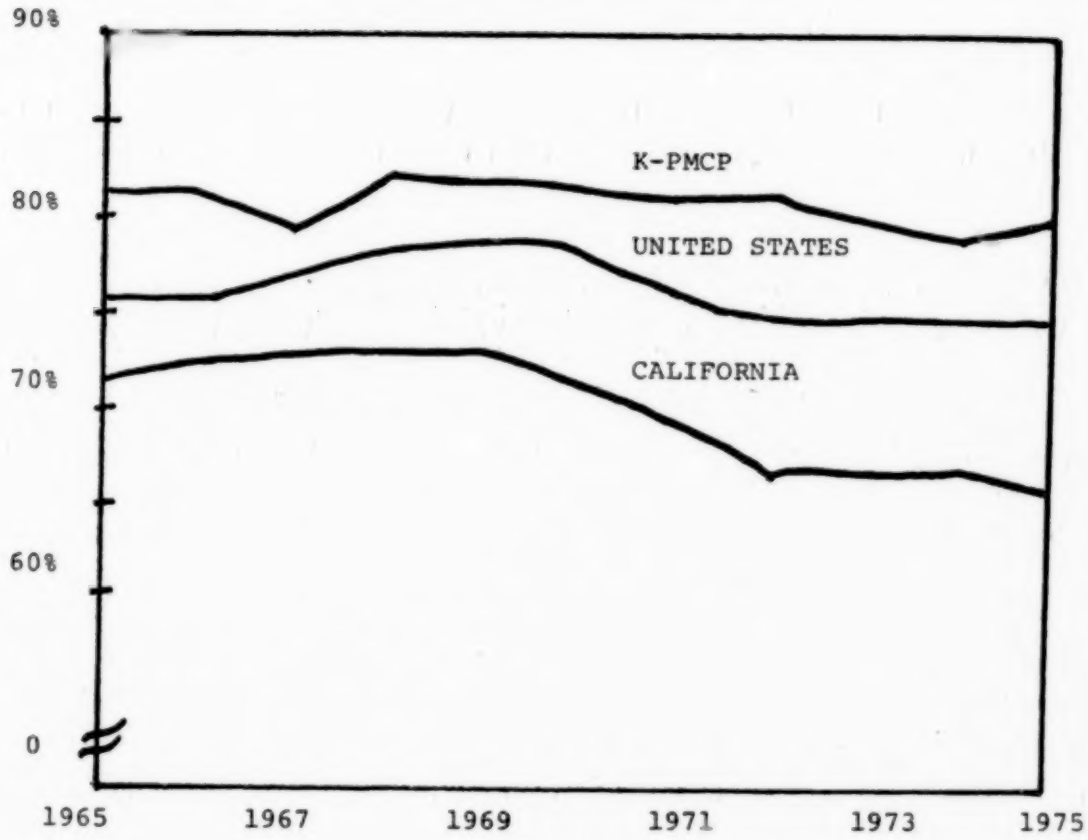


464; 1968: Table 1, p. 475; Table 3, p. 490; 1969: Table 1, p. 473; Table 3, p. 490; 1970: Table 1, p. 474; Table 3; p. 492); American Hospital Association, *Hospital Statistics,* Chicago, Illinois (1971: Table 1, p. 13; Table 3, p. 30; 1972: Table 1, p. 20; Table 5, p. 64; 1973: Table 1, p. 20; Table 5, p. 64; 1974: Table 1, p. 4; Table 5C, p. 48; 1975: Table 1, p. 5; Table 5C, p. 48); United States civilian resident population data are from *Social Security Bulletin,* Social Security Administration, DHEW, Vol. 39, No. 12, Table M-40, at 68 (December 1976). *California Population,* Department of Finance, State of California, Table 5, at 7 (May 1972), and for 1972-1975 are from *California Statistical Abstract, 1976,* State of California, Table B-1, at 6 (1976).

11. *Ibid.*

Exhibit 4

III. PERCENT AVERAGE OCCUPANCY[12]



12. *Ibid.*

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY a/k/a BLUE SHIELD OF TEXAS, *et al.*,

Petitioners,

-against-

ROYAL DRUG COMPANY, INC. d/b/a ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al.*,

Respondents.

On Appeal from the United States Court of Appeals, Fifth Circuit

BRIEF OF THE UNITED FEDERATION OF TEACHERS WELFARE FUND, AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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In The

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Respondents.

On Appeal From the United States Court of Appeals, Fifth Circuit

BRIEF OF THE UNITED FEDERATION OF TEACHERS WELFARE FUND, AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

INTEREST OF *AMICUS CURIAE*

The United Federation of Teachers Welfare Fund is an employee benefit fund established as are sult of collective bargaining between the United Federation of Teachers, a labor union which represents, for purposes of collective bargaining, teachers and other pedagogical employees employed by the City of New York, and the Board of Education of the City of New York. The Welfare Fund is funded by contributions made by the City of New York in amounts stipulated in the current collective bargaining agreement between the Union and the City. The Welfare Fund is administered by a Board of Trustees designated under the Agreement and Declaration of Trust which governs the operation of the Fund.

The Welfare Fund provides various benefits to its covered members, as defined in the Fund Plan, including medical benefits supplemental to those provided by the City of New York, dental benefits, optical benefits, accident and sickness disability benefits, death benefits, and prescription drug benefits.

Under the Prescription Drug Plan, the Welfare Fund will pay the full cost of a member's prescription drugs, no matter what the charge, providing the prescription is filled by a Participating Pharmacist. A Participating Pharmacist is a pharmacist who has entered into an agreement with the Welfare Fund accepting its prescription program together with a price schedule adopted by the Fund.

If a Non-Participating Pharmacist is used, reimbursement is made in accordance with a specific schedule of allowances. When a Non-Participating Pharmacist is used, there is no assurance that the charges will not exceed the amount that the Fund allows. In such instances, payment by the member may exceed the benefit provided by the Welfare Fund.

Each covered employee is issued an Indentification Card authorizing any Participating Pharmacy to fill prescriptions

which come within the scope of the Plan. The Identification Card certifies the member's eligibility to the Participating Pharmacist.

Prescriptions are obtained on a special blank printed by the Welfare Fund. Upon presentation of a covered prescription written on an official Welfare Fund prescription blank and Identification Card to a Participating Pharmacist, the prescription will be filled and the entire charge will be paid by the Welfare Fund in accordance with its agreement with the pharmacy.

If a prescription is filled at a Non-Participating Pharmacy, the Fund requires an original receipted bill indicating the date the prescription was filled, the prescribing doctor's name, the patient's name, the prescription number, and the name, strength, quantity and dosage of the drug prescribed. Such original receipted bills must then be submitted to the Fund for payment, and reimbursement will be made in accordance with the Schedule of Allowances on file at the Welfare Fund. Reimbursement is determined by the price the Fund would have paid for the same drug if it had been purchased at one of the Participating Pharmacies.

The prescription drug benefit is provided directly by the Welfare Fund rather than through an insurance company or other third party payor.

This *amicus* brief in support of petitioners is prompted by the concern of the Welfare Fund that the decision in this case may be sufficiently broad to affect the Fund.

The parties have consented to the filing of an *amicus curiae* brief by the United Federation of Teachers Welfare Fund. A copy of the letter evidencing these consents is on file in the office of the Clerk of the Court.

OPINIONS BELOW

The opinion of the District Court is reported at 415 F. Supp. 343. The opinion of the Circuit Court is reported at 556 F. 2d 1375.

SUMMARY OF ARGUMENT

The decision of the Circuit Court should be reversed and the complaint dismissed. The attempt by a provider of prescription drug benefits to limit the cost of such benefits by entering into agreements with pharmacies to accept a fee schedule as payment in full promotes competition, is in the best interest of consumers and does not violate the anti-trust laws.

The experience of the United Federation of Teachers Welfare Fund has shown that the agreements between the Fund and Participating Pharmacies under which Participating Pharmacies have agreed to accept the Fund's fee schedule as payment in full *fosters* competition and makes the small neighborhood drugstore better able to compete with its large chainstore or supermarket competitors. This has occurred due to the fact that while the large stores, most of which are Non-Participating Pharmacies, generally undersell the smaller neighborhood stores, most of which are Participating Pharmacies, members will nevertheless patronize the neighborhood stores because such stores are usually more convenient and the member incurs no out-of-pocket cost.

Under this arrangement there exists no incentive among members of the Fund to patronize mail order or other discount sellers. Thus, the Fund's entering into a prescription drug plan agreement with Participating Pharmacies is not anti-competitive. Rather, such agreements have helped enable small local stores to remain in business in the force of overwhelming competition from large competitors. In fact, the Fund's Prescription Drug Plan is designed to help maintain the existence of the neighborhood drugstore.

The further effect of the Fund's Plan has been to contribute toward encouraging lower drug prices. The result of this is to provide greater benefits to all its covered members with the limited funds available for the program.

In the event this Court affirms the decision of the Circuit Court herein, and if that decision is sufficiently broad to effect the United Federation of Teachers Welfare Fund, the result will be harmful to the ultimate consumers who are covered by the Fund. It is respectfully submitted that the agreements entered into between the Fund and Participating Pharmacies as described above are not anti-competitive and should not be upset by this Court.

CONCLUSION

The decision of the Court should be reversed and the complaint dismissed.

Respectfully submitted,

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IN THE

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GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et al.*,

Appellants,

against

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al.*,

Appellees.

On Appeal from the United States Court of Appeals for the Fifth Circuit

BRIEF *AMICUS CURIAE* FOR DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN and NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS WELFARE FUND

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BRIEF *AMICUS CURIAE* FOR DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN and NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS WELFARE FUND

The Trustees of the District Council 37 Health & Security Plan and the Trustees of the New York City District Council of Carpenters Welfare Fund respectfully submit this brief as *amici curiae* in support of the appellant Group Life and Health Insurance Co. ("Appellant Group Life").*

* Both the Appellant Group Life and the appellees have filed their written consent to the submission of briefs *amicus curiae* before this Court.

Interest of the *Amici*

The District Council 37 Health & Security Plan (the "Plan") and the New York City District Council of Carpenters Welfare Fund (the "Fund") are both collectively bargained trusteed employee welfare benefit plans within the meaning of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1002(1). In addition to the usual range of welfare benefits which are characteristic of trusts of this nature, both the Plan and the Fund provide a prescription drug benefit to their covered employee members and their dependents. The prescription drug benefits they respectively provide are self insured and administered in ways which bear similarities to the prescription drug insurance issued and administered by the Appellant Group Life.

The sweep of the language found in the decision of the Fifth Circuit in this case may call into question the ability of the *amici* to continue to provide a low cost prescription drug benefit to their covered members and may, in addition, call into question the ability of the *amici* to provide or continue to provide other "pre-paid" health and health related benefits to those same covered members and their dependents.

Relevant Issues Which May Not Be Adequately Presented by the Parties

The *amici* have a special interest and posture with respect to the subject matter underlying this appeal which may not be adequately brought out by the parties. The parties to this proceeding and the Court below have focused narrowly on the issue whether or not the activities com-

plained of are insulated from the anti-trust prosecution by the provisions of the McCarran-Ferguson Act, 15 U.S.C. §1011, *et seq.* ("McCarran Act"). Indeed, the question as framed and presented to this Court is limited to whether the business of insurance, for the purposes of the McCarran Act exemption, includes contracts entered into by an insurer with a third party who provides benefits to the insurer's policy holders.

This narrow issue, however, appears to assume that the complained of underlying conduct, constitutes "monopolistic or coercive activities in health provider industries." If that assumption is not brought into question, examined and rejected in this review of the decision below, it may have serious and negative implications for self insured employee welfare benefit plans, such as the *amici,* which, in their own individual ways, are seeking to reduce the cost of health-related services needed by their members.

None of the briefs heretofore submitted in this case deals with the question of whether the "group buying" activities of employee welfare benefit plans constitutes "monopolistic or coercive activities." None of the said briefs analyzes the nature and purpose of the anti-trust laws and relate that nature and purpose to the essential relationships and characteristics of a union with respect to its members. Nor are any of the parties to this case in a position to adequately brief and discuss the special relationship which causes the trustees of collectively bargained employee welfare benefit plans to engage in the group buying of prescription drugs and whether that group buying activity could possibly constitute "monopolistic or coercive" conduct within the meaning of the anti-trust laws.

According to the best available statistics there are more than 900 employee welfare benefit plans which serve more than 7 million persons and provide a prescription drug benefit substantially similar to that here in issue. These employee welfare benefit plans may not be deemed to be engaged in the business of insurance* and may not be entitled to avail themselves of the McCarran Act exemption. Their activities in providing low-cost health related benefits to their members may be seriously and adversely affected if this Court does not reject the imputation of the Fifth Circuit, that the conduct of the Appellant Group Life in this case can be deemed a violation of the anti-trust laws.**

It is the purpose of the brief submitted herewith to concentrate attention on those issues which may be unique to the *amici,* and the class they represent. The brief is intended to bridge the lacuna found in the presentation of the parties to date, which does not treat with the ramifications of this case upon the entire scheme of health provider services structured by the major employers and labor unions of this nation through trusteed employee welfare benefit plans.

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* See 29 U.S.C. §1144(b)(2)(B).

** Indeed, the operation and conduct of State Medicaid drug programs, to the extent that they are administered by cities and other political subdivisions, may well be affected by the Court's decision in this case, since they too employ substantially the same reimbursement method and participating pharmacy system as does the Appellant Group Life and, as will be shown, the *amici.* See *City of Lafayette, La.* v. *Louisiana Power & Light,* 98 S. Ct. 1128 (1978).

Statement of Case

Both the Plan and the Fund are trusteed employee welfare benefit plans established in accordance with numerous collective bargaining agreements entered into between the various constituent local unions of the District Councils involved and the employers of the employees they represent as the collective bargaining agent.

Both the Plan and the Fund serve precisely the same purpose. They receive the employer contributions provided for in the collective bargaining agreements and use those sums to provide welfare benefits tailored by their respective trustees to meet the needs of their covered members.*

The benefits provided fall into the usual categories associated with trusts of this nature. Covered members, in accordance with the rules of the relevant trust, are provided death and disability benefits as well as reimbursement for dental, optical, hospitalization, surgical, major medical and prescription drug expenses. Gainsaid, the status and character of the prescription drug benefit ("Drug Benefit") will be the primary focus of this brief.

Both the Plan and the Fund provide a Drug Benefit to their covered members which reimburses the members for their out-of-pocket cost in purchasing prescription drugs to the extent that out-of-pocket cost does not exceed the

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* The Plan provides benefits to approximately 300,000 persons and the Fund to approximately 45,000 persons.

"average wholesale price"* of the prescription drug in question plus, in the case of the Plan, the sum of $1.25 and, in the case of the Fund, the sum of $2.00. Any covered member of the Plan or Fund may obtain this reimbursement by filing a claim, on the forms provided, after he or she has filled and paid for the prescription at a pharmacy of his or her own choosing.

In addition to this form of direct reimbursement for drug costs incurred by covered members, both the Plan and the Fund, on behalf of their covered members and in order to further assist them in adjusting to their ever increasing health care costs, have entered into agreements with pharmacies under which the pharmacy agrees to provide the prescription drug to the covered member at a charge set by reference to a pricing formula. In the event that the benefit provided to the covered member by the trust equals the pricing formula, the covered member can fill his or her prescription without any out-of-pocket cost since the pharmacy will look to the trust for its entire payment. In the event that the benefit provided to the covered member by the trust is less than the pricing formula, the covered member can fill his or her prescription by paying the pharmacist the difference between the dollar amount of the benefit and the pricing formula; the pharmacist then looking to the trust for the balance. Any pharmacy which enters into such an agreement is known as a "Participating Pharmacy."

* The "average wholesale price" is determined by reference to DRUG TOPICS RED BOOK: *The Pharmacists Guide to Products and Prices* (Medical Econ., 1978), a book in standard usage in the pharmaceutical industry and published annually and supplemented monthly.

These arrangements are, due to the force of competition, fairly standard in operation in any given area. Consistent with the practices in the area served by both the Plan and the Fund, individual pharmacists have agreed to become Participating Pharmacies and provide prescription drugs to relevant covered members at a charge which will equal the average wholesale price of the drug in question plus the sum of $2.00 ("Pricing Formula"). Under such an agreement, a covered member of the Fund who chooses to fill his or her prescription at a Participating Pharmacy will have no out-of-pocket cost associated with the purchase since the Pricing Formula equals the amount of the reimbursement the Fund provides and which it will pay to that Participating Pharmacy.* On the other hand, a covered member of the Plan who chooses to fill his or her prescription at a Participating Pharmacy will have a $0.75 out-of-pocket cost for each prescription since the Pricing Formula exceeds the amount of reimbursement the Plan provides by sum of $0.75** (Pricing Formula = average wholesale price plus $2.00: Plan reimbursement = average wholesale price plus $1.25).

Operationally, the interrelationship between the Plan or Fund, its respective covered members and the Participating Pharmacy is simple. The Plan and the Fund each provide their respective covered members with an identification card. If the covered member chooses to fill his or

* If the covered member chooses to go to a non-participating pharmacy, this same sum will be paid directly to that covered member.

** Competition for this business is so keen that many Participating Pharmacies have posted notices saying that they voluntarily waive this $0.75 direct payment by a covered member of the Plan—notwithstanding the fact that nothing, other than their own business judgment, bars them from collecting it.

her prescription at a Participating Pharmacy the card is presented along with the prescription form. The Participating Pharmacy fills the prescription and identifies it on a charge slip. If the prescription is filled for a Fund member, the Participating Pharmacy will then give the prescription to the member, ask him to sign the charge slip, and send the executed slip to the Fund for payment.* The exact procedure is followed for Plan members except that, for reasons heretofore stated, a Plan member will pay the Participating Pharmacy $0.75 before he or she can receive his or her filled prescription.

Neither the Plan nor the Fund exclude, otherwise restrict or place any special limitation upon who can become a Participating Pharmacy. All licensed druggists are entitled to and may join the respective programs if they offer to supply prescription drugs to the relevant covered members in accordance with the Pricing Formula. There are no restrictions placed upon a Participating Pharmacy apart from its agreement to adhere to the Pricing Formula—and that agreement may be terminated by it at any time. He is not required to make home delivery or provide any special ancillary services. To the contrary, if he provides a special service, he is not barred from separately charging the covered member for each such service. On the other hand, the covered member can intelligently choose whether he or she wants to pay for such additional services or just go on the "no frills flight." The net result is that, as to this relevant class of consumer, he or she is no longer subject to the hidden costs of a "tie-in sale" of ancillary

* As a matter of practice these slips are accumulated for various periods of time and then sent to the Fund or Plan, as the case may be, for bulk payment.

services which he or she may not want to pay for. This consumer now has the ability to exercise a real and intelligent choice in the market place.

Under the rules of both the Plan and the Fund, the covered member is *not* restricted in his or her choice of druggist. Whether he or she uses a Participating Pharmacy or any other druggist, both the Plan and the Fund will pay the same amount of reimbursement benefit directly to him or for his benefit. What these Trusts have done on behalf of their beneficiary members is to help those members find places where they can maximize the fixed dollar benefit they are entitled to. This type of advice to their covered members not only supports the goals of enlightened consumerism but also represents the fulfillment of the Trustees' obligations to their covered member beneficiaries. See 29 U.S.C. §1104. See also Int. Rev. Code of 1954 §501(c)(9) and regulations thereunder.

Question Presented

Over and apart from the issue to be briefed and argued by the parties to this case—whether the McCarran Act exemption applies to the complained of activities of Appellant Group Life—a more basic question may require consideration by this Court:

> Whether the provision of low cost prescription drug services by employee welfare benefit trusts to their covered member beneficiaries through an offer made to all pharmacies on proportionally equal terms is in and of itself a violation of the anti-trust laws?

It is respectfully submitted that it is not.

POINT I

A combination of consumers for the purpose of engaging in co-operative buying to effect economies of scale by mass purchasing does not violate the anti-trust laws of the United States.

A concern for the consumer's benefit is the fundament upon which the anti-trust policy of this nation is based. It requires little citation of authority to state that the anti-trust laws seek to protect the market place from practices which Congress has determined will have an adverse impact upon the consuming public. Indeed the legislative history of the Sherman Act, 15 U.S.C. §1, conclusively establishes that concern for the consumer was the intent underlying its passage and, in enforcing that Act, "the Courts should be guided exclusively by consumer welfare and economic criteria which that value premise implies". Bork, *Legislative Intent and the Policy of the Sherman Act,* 9 J. Law & Econ., 7, 11, 47 (1966): See also Bohling, *Franchise Terminations Under the Sherman Act: Populism and Relational Power,* 53 Texas L. Rev. 1180, 1189 (1975).

It is the possible perversion of that intent by appellees, under the guise of this private action under the Sherman Act, which has compelled the *amici* to file this brief. The *amici* are trustees, who, on behalf of their member beneficiaries, are charged, both by contract and law, with maximizing the benefits they must provide for the exclusive use of their covered member beneficiaries. As a trust entity or as individual trustees they may not gain any special advantage for themselves in the market place. They can neither seek nor retain any economic profit. They may not and do

not compete, in any real sense, as an economic unit. They have a simple and single purpose, to wit: To hold the funds that they receive on behalf of their covered members and use that money to effect the most advantageous purchase of health related goods and services on behalf of their covered members—who are, needless to say, the ultimate consumers of those same goods and services.

In a manner of speaking, these trusts are a method by which consumers have combined to improve their purchasing power in the market place. In this age of monopolistic competition, where the vigor of competitive practice in many fields resides exclusively in the ability of purchasers to exercise countervailing power, it is only the impact of mass buying of this nature which keeps some restraint upon price rises. See, Mueller, *Anti-Trust and Economics: A Look at "Competition"*, 10 St. Louis U.L.J. 482 (1962); Galbraith, American Capitalism, Chapt. IX (rev. ed. 1956).

Amici respectfully suggest that if there exists today one single field of economic enterprise that cries out for a "countervailing power" to maintain the integrity of the competitive market, it is that area of our economy occupied by the health providers. Neither the government nor major economic units such as Appellant Group Life have been able to have any impact upon this branch of our economy, which is best characterized by its uniquely inelastic demand.

There is no substitute product for health care. A consumer cannot choose to "do without" when it comes to filling a prescription and it is for that reason that certain consumers, such as the covered members of the Plan and Fund, have chosen to express themselves in the market place as a collective entity.

This concept is neither new nor novel and, since 1962, has received approval by the courts which have addressed this question. Since that time, the courts have recognized the propriety, notwithstanding the anti-trust laws, of group buying in the form of "voluntaries", "marketing cooperatives", "consumer cooperatives", "buying groups", and other entities through which small-scale enterprises have banded together to obtain the benefits of mass purchasing not otherwise available to them individually.* *Alhambra Motor Parts* v. *F.T.C.*, 309 F.2d 213, 219-21 (9th Cir. 1962); *Tri-Valley Packing Association* v. *F.T.C.*, 329 F.2d 694, 706-9 (9th Cir. 1964); *Alterman Foods Inc.* v. *F.T.C.*, 497 F.2d 993, 999-1000 (5th Cir. 1974). See also *Wholesalers: Brains and Muscle Extend Winning Streak,* Vol. 57 No. 4, PROGRESSIVE GROCER 127 (April, 1978) ("voluntaries" and "cooperatives" accounted for more than 81% of the total wholesale grocery sales volumes in the U.S. in 1977).

Where various small enterprises, as resellers of a product, may band together for the purpose of obtaining lower prices on their purchases of that product, it would seem self evident that analogous combinations of consumers, as the ultimate user of a product, may do the same.

The *amici,* moreover, are more than a grouping of consumers randomly brought together because of the increas-

* The most recent expression of Congress' willingness to give special consideration to this type of "consumer" combination for this purpose, albeit in 1936, is to be found in 15 U.S.C. §13(b) which provides that nothing in the Robinson-Patman Act ". . . shall prevent a cooperative association from returning to its members, producers or consumers the whole or any part of the net earnings or surplus resulting from its trading operations . . ." See also remarks of Congressman Utterback at 80 CONG. REC. 9419 (1936).

ing pressures of the economic market place. They represent a group of consumers who are also bound together in fraternal association through their common membership in their respective unions. This fraternal association gives them rights and privileges which may transcend those which could inure to a randomized group of consumers. This Court, in earlier decisions, has recognized the special qualities of this type of relationship and has already suggested the essence of the doctrine that the *amici* are urging—that a union or union-related body, as the representative of its members, may exert its collective strength and economic power to obtain goods or services for those members at standardized quality and low-cost rates. *Brotherhood of R.R. Trainmen* v. *Virginia State Bar,* 377 U.S. 1 (1964); *United Mine Workers* v. *Illinois State Bar,* 389 U.S. 217 (1967); see also *N.A.A.C.P.* v. *Button,* 371 U.S. 415 (1963).

The reverse side of this precise issue—a refusal to deal—has been considered by the lower courts and decided in ways which are also supportive of the position urged by the *amici.* Since 1952, the welfare fund of the United Mineworkers has negotiated contracts with individual hospitals which fixed the *per diem* sum that could be charged to members of the welfare fund. In 1971 the welfare fund could not reach price agreement with the Webster County Memorial Hospital and accordingly threatened to restrict the hospitalization of its members in that hospital to emergency cases only. The Hospital thereupon claimed that the welfare fund's refusal to deal with it, except on a limited basis, was unlawful under the Sherman Act and an illegal boycott by the fund and its beneficiaries. It accordingly sued the welfare fund seeking appropriate relief.

The dismissal of that suit by the District Court for failure to state a cause of action was affirmed by the Court of Appeals in *Webster Cty. Mem. Hospital* v. *United Minc Workers of Amer. Welfare and Retirement Fund of 1950,* 536 F.2d 419 (D.C. Cir. 1976). The language used by the Court of Appeals in its short opinion is particularly relevant to the *amici's* position. The Court said:

> "The complaint alleges no more than that the Fund has engaged in activities Congress envisaged in enacting §302 of the Taft-Hartley Act[*]. While we do not decide a §302 fund is immune from the antitrust laws, we find nothing unreasonable in the actions of the Fund alleged here. . . .
>
> • • •
>
> "In our view, the status of the Fund is similar to that of a group buying agent negotiating a price for medical care on behalf of its beneficiaries. While such a cooperative may engage in anticompetitive behavior which runs afoul of the antitrust laws [citation] neither the mere existence of a . . . fund nor negotiations with suppliers of medical care as alleged in this case, without more, amounts to an unreasonable restraint of trade. The fact that the miners are not technically 'members' of the Fund (as in the case of a cooperative), but 'beneficiaries' of the Trust and third party beneficiaries of its contract relationships, does not undercut the reality of the situation. The Fund was established for the benefit of union members, and operates on their behalf." *id.* at 420.

The Court of Appeals recognized the realities of the case before it. It saw that the prime purpose of a trusteed

* The *amicus* Fund, similarly, is a §302 Tart-Hartley Trust.

welfare fund was to serve the health needs of its members; that in carrying out that purpose it had to negotiate and standardize the price that its members must pay, directly or indirectly, for the components of health care; and that at all times the welfare fund, as a form of "group buying agent", was exclusively serving the purposes of its members. It therefore held that the welfare fund's refusal to deal with a health care provider who refused to adhere to a standardized low-cost rate for services did not violate the Sherman Act. See also *Nankin Hospital* v. *Michigan Hospital Service,* 361 F.Supp. 1199, 1207-10 (E.D. Mich. 1973).

Surely if this reasoning is valid for the facts of the *Webster County* case, it has even greater validity when applied to the activities of the *amici.* Unlike the Mineworkers Welfare Fund, the *amici* have refused to deal with no one. They not only stand ready to directly deal with any and every pharmacy which will adhere to their cost standards, but they also allow their members free choice to deal with any pharmacy the member wishes to deal with—without any dimunition in reimbursement amount. They have merely provided an option to their respective covered members which will allow those members to cover the entire cost of their prescription drugs for the amount that the Plan* or the Fund provides as a drug cost reimbursement benefit.

Basically what the appellees in the instant case are complaining of is that the Appellant Group Life, like the *amici,* has created standards governing the price it is willing to pay

* As previously noted, members of the Plan must pay the minor sum of $0.75 out-of-pocket costs for each prescription.

for prescription drugs required by *its* beneficiary policy holders. Nothing has been offered to show that these standards are in any way arbitrary or unreasonable. To the contrary, these standards are consistent with national policy intended to hold down the medical costs which have soared proportionately higher than any other cost in the nation's economy—and, parenthetically, precisely the same standards which are used under Medicaid.

The objective of any prescription drug program is to confer a benefit upon the consumer—the precise goal of the anti-trust laws. It does not seek to injure competition or gain a competitive advantage for a related enterprise. It openly seeks merely to maximize its consumer members' power in the market place. Quite obviously, the individual consumer does not have the economic strength to obtain the benefits of quantity purchasing. This individual consumer must look to collective action to achieve the advantages of scale which are inherent in the exercise of combined purchasing power. Where that power is applied, as it is by the *amici*, in an equitable fashion available on equal terms to all retail suppliers of the product; where access to the program by sellers of drug services entails no loss; the resultant restraint on exorbitant prices has a minimal effect on competition and serves the higher goal of consumer protection—the very foundation of the Sherman Act.

POINT II

In the balancing of social equities under our anti-trust policy lesser goals must give way to the imperatives of constitutional protections and basic economic policy.

It is indeed anomalous that appellees in this case are seeking to use the Sherman Act in a way which is detrimental to the consumer—the very group that this Act was designed to protect. The Sherman Act was designed by Congress to protect the consumer by insuring that large economic entities could not crush their small competitors and achieve such a dominant position in the market place as would allow them to dictate prices to the consuming public. *United States* v. *South-Eastern Underwriters Assn.*, 322 U.S. 533, 553-5 (1944).

The economic realities of the market place at the time of the passage of the Sherman Act are well known. The small entrepreneur in an atomized market was being threatened by the " '[t]rusts' and 'monopolies' [which] were the terror of the period" *id.* at 553. It was believed then, as it is believed now, that the consumer must be protected from these large trusts and monopolies and the Sherman Act was passed to prevent these predatory economic entities from achieving dominance.

The appellees now come before this Court and urge that the Sherman Act was exclusively passed to benefit them, small shopkeepers, and seek the relief it offers without regard or reference to the impact of such relief upon the consumer. They are in essence asking that this Court permit the use of the anti-trust laws as "a sword against the

consumer." *NBO Industries Treadway Cos., Inc.* v. *Brunswick Corp.*, 523 F.2d 262, 279 (3rd Cir. 1975), vac. other grds. *sub nom., Brunswick Corp.* v. *Pueblo Bowl-O-Mat Inc.*, 429 U.S. 477 (1977): see also *In the Matter of Coca-Cola Company, et ano.*, Opinion F.T.C. Docket No. 8855, pp. 65-7 (April 25, 1978).

Appellees do so by urging the simplest of arguments. They claim that Appellant Group Life, on behalf of its consumer policy holders, is entering into agreements with druggists whereby standardized low prices are agreed upon, the natural consequence of which is to encourage, if not coerce, these policy holders to do business only with the aforesaid druggists. Appellees, who have refused to enter into such agreements are accordingly injured for they cannot effectively compete under these circumstances. It therefore follows, say appellees, that they, as competitors, are injured, trade is thereby restrained and the Sherman Act applies.

It is respectfully submitted that appellees are in error on all counts. First, the Sherman Act does *not* protect appellees as competitors. As this Court had occasion to reaffirm last year "the anti-trust laws, however, were enacted for 'the protection of competition not competitors', Brown Shoe Co. v. United States, 370 U.S. [294] at 320 [1962]" *Brunswick Corp.* v. *Pueblo Bowl-O-Mat, supra,* at 488. The fact that appellees may suffer economic injury because of their inability or unwillingness to adjust to changes in the market, does not give rise to a cause of action under the Sherman Act. The Sherman Act does not shield appellees from the impact of changes in the market place nor does it protect a particular competitor's manner of conducting his business.

Second, the mere fact that there exists a contract or agreement which limits one party's ability to price its product does not in and of itself make out a violation of the anti-trust laws. As stated by Mr. Justice Brandeis as long ago as 1918:

> "[T]he legality of an agreement . . . cannot be determined by so simple a test as whether it restrains competition. Every agreement concerning trade, every regulation of trade, restrains. To bind, to restrain is of their very essence. The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the Court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be obtained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences." *Chicago Board of Trade* v. *United States,* 246 U.S. 231, 238 (1918).

It is quite obvious that every contract will restrain trade since that which is contracted for is purchased at a price "fixed" by the agreement between the buyer and the seller. The essential question is whether the restraint is a reasonable one. Here the restraint established by the prescription drug plans of Appellant Group Life and the *amici* merely fixes the price at which the relevant plan will purchase

drugs. It does not fix the price at which other consumers or other plans will make their purchases. Indeed, it does not even fix the price at which its subscribers will purchase drugs since the appellees have conceded that a certain percentage of the subscribers continued to purchase from non-participating druggists. The only price the plans fixed was the price which they were willing to pay for pharmaceuticals.

Should this Court countenance the views of the appellees herein, it would impose a powerful deterrent to efforts of small, as yet unorganized, consumers to band together in order to protect their interests as well as bid fair to destroy the overall structure of co-operative purchasing devised to date for the purpose of putting a check on escalating medical costs—a right of free association which is entitled to constitutional protection. See *Brotherhood of R.R. Trainmen* v. *Virginia State Bar, supra; United Mine Workers of America* v. *Illinois State Bar, supra; N.A.A.C.P.* v. *Button, supra.*

For all of the foregoing reasons, it is respectfully submitted that the determination herein of the Fifth Circuit, that a drug prescription group plan, whether insured or not, represents a "fixing of prices" is not supported by either the facts or the decisional law; is contrary to the economic policy of our anti-trust statutes; conflicts with the actualities of the market place; and is at odds with the underlying rationale of this Court's prior decisions upholding the constitutional right of groups of citizens to band together for their social and economic betterment and protection.

Conclusion

The decision of the Fifth Circuit below should be reversed on the grounds that the conduct complained of by the appellees does not constitute a violation of the anti-trust laws.

Respectfully submitted,

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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, et al.,

Petitioners,

vs.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, et al.,

Respondents.

On A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF OF THE STATE OF OHIO AS AMICUS CURIAE

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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, et al.,

Petitioners

vs.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, et al.,

Respondents.

On A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF OF THE STATE OF OHIO AS AMICUS CURIAE

This brief is filed for the State of Ohio by its Attorney General in support of Respondents, pursuant to Supreme Court Rule 42(4).

Interest Of Amicus

The Attorney General of Ohio is the chief law officer for the State of Ohio and is specifically charged with representing the State's fundamental commitment to antitrust policy in state and federal courts. Ohio Rev. Code Sections 109.02 and 109.81 (Page 1978). This case is of direct interest to the State of Ohio in two ways.

First, Petitioners' attempt to extend the McCarran Act antitrust exemption to non-insurance businesses where competitive policy should prevail runs directly counter to the State's general interest in maximizing the role of the market system.

Second, the State of Ohio is actively committed to using market forces and vigorous antitrust enforcement as methods of cost containment in the health care industry. See Borsody, "Hospitals Enter Antitrust Era," 52 *Hospitals* 59, 60 (May 1, 1978). Prior to 1975, federal and state antitrust enforcement in the health care industry had been virtually nonexistent for the 23 years following *U.S. V. Oregon State Medical Society,* 343 U.S. 326 (1952).

On July 9, 1975, the State of Ohio filed an antitrust action against the Ohio State Medical Association and its wholly owned Blue Sheild subsidiary, Ohio Medical Indemnity, Inc. The suit asserts that the Medical Association has used its wholly owned Blue Shield subsidiary, Ohio Medical Indemnity, Inc. services market, and should be forced to divest the company in order to restore competitive market forces. See, The Skyrocketing Cost of Health Care: The Role of Blue Shield, *Hearings Before Subcomm. on Oversight & Investigations, H. Comm. on Interstate & Foreign Commerce,* 95th Cong., 2d Sess. (1978) (testimony of Attorney General William J. Brown). On the anticompetitive origins and impact of physician dominated Blue Shield plans generally, see, Goldberg & Greenberg, "The Effect of Physician-Controlled Health Insurance," *J. Health Politics, Policy & Law* 48 (1977) and Council on Wage & Price Stability, *A Study of Physicians' Fees* 31 (March, 1978).

In September, 1976 the District Court held the McCarran Act should not be extended to the principal defendant, the Ohio State Medical Association, while granting immunity to the Blue Shield plan. *Ohio v. Ohio Medical Indemnity, Inc.*, 1976-2 Trade Cases paragraph 61, 128 (S.D. Ohio). Although the cases are distinguishable, Petitioners' expansive reading of the "business of insurance" to encompass an alleged pharmacy-insurer conspiracy could jeopardize the State of Ohio's case against the Ohio State Medical Association. Since Ohio's Blue Shield litigation is a vital part of the State's effort to arrest the rising cost of health care and to apply market forces to the medical marketplace, the State has filed this *amicus* brief on behalf of Respondents.

Summary Of Argument

The McCarran Act was solely intended to preserve state insurance department regulation and taxation of the *insurance business,* as the plain meaning of the key phrase "business of insurance" denotes. There is not a shred of evidence, and much to the contrary, that Congress ever considered state insurance departments to have the requisite authority, expertise or incentives to regulate the retail drug market or any other non-insurance business. If states choose to regulate other businesses through their insurance departments, then the *Parker v. Brown* doctrine is better suited for determining inter-industry antitrust exemptions and will fully protect state cost containment programs directed at the health care industry.

More specifically, a careful review of the McCarran Act's genesis, its purpose, its language, Congress' concept of state insurance department regulation, the nature of Texas' insurance regulation here and relevant Supreme Court precedent cumulatively establishes that Congress never intended the "business of insurance" to cover trade restraints imposed on non-insurance businesses.

Contrary to Petitioners' claim, the McCarran Act was not passed to effect a return to the pattern of exclusive state supervision of insurance that existed before this Court's decision in *U.S. v. South-Eastern Underwriters Assn.*, 322 U.S. 533 (1944). Congress rejected a blanket federal antitrust exemption for insurance. Instead, Congress adopted the entirely different approach of the National Association of Insurance Commissioners

("NAIC"), which was to preserve state regulation of insurance without emasculating the federal antitrust laws. Accordingly, the McCarran Act reflects federalist policies, with state policy generally prevailing over federal in the event of a conflict.

Congressional concerns were confined entirely to the insurance industry, so that the terms "business of insurance" and "every person engaged therein" had a plain and unambiguous meaning. Insurance was a self-contained business operating primarily on the basis of actuarially determined costs beyond the industry's control. Blue Shield plans were then so new and so different from traditional insurance, with their participating provider contracts and physician control, that they were generally not even considered a form of "insurance."

Similarly, Congress only recognized the expertise of state insurance departments insofar as they regulated the insurance business. Congress never intended the McCarran Act to cover state insurance department regulation of non-insurance businesses. General antitrust principles expressed by this Court directly support limiting the McCarran Act to state regulation of the insurance business, thus avoiding, for example, the danger that state insurance departments will favor their regulated industry at the expense of unregulated commerce such as the pharmacy market.

The Court's *National Securities* decision is faithful to Congress' specific focus on the insurance industry and does not support Petitioners' effort to include virtually any industry doing business with insurers within the "business of insurance."

The Texas State Board of Insurance approval of Blue Shield's pharmacy policies constitutes traditional insurance department regulation of the insurer-insured relationship. Texas' mere approval of the policies as to their impact on policyholders does not manifest a policy to restrain trade in the competitive retail drug market. Petitioners' alleged trade restraints on the pharmacy market are thus outside the "business of insurance."

The McCarran Act specifically provides that an antitrust exemption is available to "every person engaged" in the "business of insurance". Yet, the alleged conspiracy in this case involves Blue Shield and pharmacists who are not themselves engaged in the business of insurance. As this Court recently reiterated in *National Broiler Marketing Assn. v. U.S.*, 46 U.S.L.W. 4620 (June 13, 1978) when an otherwise exempted party combines with a non-exempt party to violate the antitrust laws, then neither party may claim the antitrust exemption.

Congress' unmistakable intention of confining the McCarran Act to the ordinary meaning of the "business of insurance" cannot be overcome by dire predictions about the demise of cost containment measures by the states and by insurers. First, Congressional intentions are controlling in the interpretation of statutes. Second, the dire predictions are simply unfounded, since the *Parker* doctrine and normal antitrust case law make clear that legitimate cost containment efforts by health insurers and the states are fully protected and permissible.

I.

CONGRESS NEVER INTENDED THE "BUSINESS OF INSURANCE" TO COVER TRADE RESTRAINTS IMPOSED ON NON-INSURANCE BUSINESSES.

A. Introduction: The Federalist Nature of the McCarran Act

Petitioners demonstrate a fundamental misunderstanding of the history and purposes of the McCarran Act when they argue that the Act granted insurance regulation "exclusively to the states" and "explicitly renounced the exercise of such power in deference to state regulation." Pet. Brief 12, 17. (Footnote omitted.) As a result, a brief analysis of the Act's history, language and purposes is in order.

Contrary to Petitioners' assertions, the McCarran Act is grounded on a fundamentally federalist policy of accommodating federal and state authority over insurance, with state policy generally prevailing over federal when there is a conflict.

The history of the McCarran Act may be traced to November, 1942 when an antitrust indictment was returned against the South-Eastern Underwriters Association ("S.E.U.A."). The indictment attacked a fire insurance company cartel that fixed premium rates and boycotted non-complying insurers, agents and policyholders. *U.S. v. South-Eastern Underwriters Assn.*, 322 U.S. 533-36 (1944).

Congressional responses to the S.E.U.A. litigation followed two distinct approaches. The first approach was to totally exempt the insurance industry from the federal antitrust laws, and lasted from fall, 1943 to fall, 1944. [1] Central to the defeat of a blanket antitrust exemption for insurance were three factors: Senate opposition, the certainty of President Roosevelt's

1 Extensive hearings on the total exemption bills were held between October, 1943 and June, 1944. See Joint Hearings Before the Subcomm. of the Comm. on the Judiciary on S. 1362, H.R. 3269 & H.R. 3270, 78th Cong., 1st Sess. The Senate rejected the total exemption bills on September 21, 1944. [90 Cong. 6565 (1944).]

veto [2], and general opposition by the insurance industry and state insurance commissioners. Mertz, "The First Twenty Years--A Case-Law Commentary on Insurance Regulation Under the Commerce Clause", *1963-64 Proc., ABA Sec. on Ins., Neg. & Comp. L.* 153, 157. The notion of exclusive state supervision of insurance died with the total exemption bills in the fall of 1944.

The second stage of Congressional reaction to S.E.U.A. was the entirely different approach of the National Association of Insurance Commissioners ("NAIC"), a phase which began in the fall of 1944 and ended with the enactment of the McCarran Act in March, 1945. The NAIC's basic purpose was simply to preserve state regulation and taxation of insurance without emasculating the federal antitrust laws:

> The decision of the United States Supreme Court in the South-Eastern Underwriters case confronted Congress, the State Legislatures and the Insurance Commissioners with a problem -- *the task of preserving state regulation of insurance and at the same time not emasculating the federal anti-trust laws.* [NAIC, *Monitoring Competition* 23 (1974). (Emphasis added.)]

They never sought nor did Congress ever consider again exclusive state jurisdiction. [3] Instead, a fundamentally federalist, two-pronged approach of accommodating federal and state authority over insurance was taken by the NAIC and expressly adopted by Congress in the McCarran Act. First, Commerce

[2] Rep. Hancock, a vigorous proponent of the total exemption approach, admitted as much:

> I was a strong supporter last year of the Walter bill, and I would support it today, plus the provision with reference to taxes. *But we believe we cannot pass that bill as the Senate is now constituted, and we are told with some assurance that the President would veto it.* [91 Cong. Rec. 1087 (Feb. 14, 1945). (Emphasis added.)]

[3] As one influential trade journal observed:

> The commissioners are in accord, but nowhere does it appear that they are for *exclusive* supervision of insurance by the States to the utter and complete exclusion of any sort or kind of Federal jurisdiction. Doubtless they see the handwriting on the wall. [Spectator Prop. Ins. Rev., November 30, 1944 at 5. See also, e.g., NAIC, *Monitoring Competition* at 35 (1974) & 91 Cong. Rec. 478 (1945) (Senators McKellar & Ferguson).]

Clause threats to the existence of state insurance supervision were removed, and second, state primacy in the event of a conflict with federal policy was generally established.

The first task is the subject of sections 1 and 2 (a) of the NAIC bill and the McCarran Act, which were specifically tailored solely to preserve state regulation and taxation from the Commerce Clause threats raised by the Court's *S.E.U.A.* decision. [4] Three House and Senate reports [5] demonstrate that Congressional purposes were the same as the NAIC's, as this Court observed in its first McCarran Act decision: [6]

> [T]hough Congress had no purpose to validate unconstitutional provisions of state laws, except in so far as the Constitution itself gives Congress the power to do this by *removing obstacles* to state action arising from its own action or by *consenting* to such laws, H.Rep. No. 143, 79th Cong., 1st Sess., p. 3, it clearly put the full weight of its power behind existing and future state legislation *to sustain it from any attack under the commerce clause* to whatever extent this may be done with the force of that power behind it, subject only to the exceptions expressly provided for.

[4] The long neglected but vital NAIC memorandum of law demonstrating this proposition is reprinted with the original NAIC bill and other material at 90 Cong. Rec. A 4403 - 08 (November 16, 1944). See generally Weller, The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy, 1978 *Duke L. Rev.* (forthcoming.) For a comparison of the NAIC Bill to the McCarran Act, see *1945 NAIC Proceedings* 157-60.

[5] H.R. Rep. 143 at 3; H.R. Rep. 68 at 2; and S. Rep. 20 at 1-2, 79th Cong., 1st Sess. (1945).

[6] *Prudential Ins. Co. V. Benjamin,* 328 U.S. 408, 430-31 (1946). The Court's "removing obstacles" and "consenting" language refer to the Commerce Clause doctrines of silence and consent upon which the NAIC specifically based sections 1 and 2 of the McCarran Act. See NAIC legal memorandum reprinted at 90 Cong. Rec. A 4406-08 (November 16, 1944).

The second task was to "minimize conflict" [7] between federal and state policy and, in the event of a conflict, to provide that state policy prevails. These prinicples are basically codified in section 2(b)'s "invalidate, impair, or supersede" language. [8] This unmistakably federalist provision, calling for the accommodation of federal and state authority whenever possible and for preemption only in the event of an irreconcilable conflict, apply to the federal antitrust laws by virtue of section 2(b)'s unambiguous terms and history. [9]

7 *Id.* at A 4407. Section 2(b) applies to all federal statutes except as provided in sections 3 and 4. On federalism generally, see *Merrill, Lynch, Pierce, Fenner & Smith, Inc. v. Ware,* 414 U.S. 117, 127 (1973).

8 Section 2(b) provides:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance, *Provided,* That. . . the Sherman Act, . . . the Clayton Act, and the. . . Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

9 Section 2(b) as originally proposed by the NAIC and introduced as S. 340 by Senators McCarran and Ferguson consisted of the first clause alone and applied to the Sherman and Clayton antitrust laws. The House accepted this standard for the antitrust laws. See H.R. Rep. 143, 79th Cong., 1st Sess. (1945) and *Insurance Field-Life ed.,* February 9, 1945 at 3, 27-28. On the other hand, the Senate demanded the states act consistently with the Sherman and Clayton Acts and passed S. 340 with an amendment deleting them from section 2(b)'s standard. 91 Cong. Rec. 488 (Jan. 25, 1945). The proviso clause emerged as the compromise between the House and Senate versions of section 2(b). See 91 Cong. Rec. 1396, 1442-44, 1477-89 (1945).

This generally neglected but highly significant evolution of section 2(b) proves that the standards of both clauses must be met before federal antitrust immunity under the McCarran Act should be granted. All of the evidence indicates that the House-Senate compromise added the proviso to tighten, certainly not to loosen, the "invalidate, impair, or supersede" test the House had agreed to apply to the Sherman and Clayton antitrust laws. See generally Weller, *supra.*

True to Congressional purposes, this Court established at the outset of McCarran Act jurisprudence that principles of federalism favoring the accommodation of federal and state authority are to be applied in construing the Act:

> The versality with which argument inverts state and national power, each in alternation to ward off the other's incidence, is not simply a product of protective self-interest. *It is a recurring manifestation of the continuing necessity in our federal system for accommodating the two great basic powers it comprehends. [Prudential Ins. Co. v. Benjamin,* 328 U.S. 408, 413 (1946). (Footnote omitted.)]

The McCarran Act also served to harmonize federal and state authority over insurance in two additional and vitally important ways that are easily overlooked with the passage of time. First, the Act made clear that the activist Roosevelt administration would *not* usurp state insurance commissioners and establish a federal insurance regulatory agency, at least for the present. The fear of federal obliteration of state insurance departments either through the enactment of a federal regulatory statute or by operation of the Commerce Clause was the brooding omnipresence that singularly motivated the NAIC at the time. [10] Second, although section 3(a)'s moratorium provision has long since lasped, it was of critical importance at the time. The Roosevelt administration fought for a short moratorium to limit what amounted to a complete antitrust exemption to as short a time as possible and to avoid the running of the statute of limitations. Others argued, successfully, for a longer moratorium for the states and the insurance industry to come into compliance with the Act and *SEUA.* See, e.g., 45 *Best's Life News* 12 (Jan., 1945).

Thus the McCarran Act constitutes a far narrower response to the *S.E.U.A.* litigation than Petitioners assert. The political mood of the time eliminated anything resembling a blanket antitrust exemption for insurance, resulting in a text carefully grounded in federalist principles and intended to preserve state regulation and taxation without emasculating the federal antitrust laws.

10 See, e.g., Senator Ferguson spoke of federal officials "licking their chops" to regulate insurance in an address to the NAIC. *1947 NAIC Proc.* 69, 74. See also, e.g., *S.E.U.A.,* 322 U.S. 586 (J. Jackson, dissenting).

B. Congress Used the "Business of Insurance" In Its Ordinary Sense To Refer To The Insurance Industry And Never Understood It To Embrace Trade Restraints Imposed On Non-Insurance Markets

The phrase "business of insurance," like the McCarran Act itself, has its roots in the *South-Eastern Underwriters* litigation. The price fixing conspiracy among insurance companies challenged there was wholly intra-industry and this same intra-industry focus prevailed throughout Congressional deliberations leading to the passage of the McCarran Act. Insurance companies, agents, brokers and adjusters were the principal "persons engaged" in the "business of insurance" under section 2(a) and concerted statistical programs, ratemaking, agent and broker commission setting, reinsurance and claims adjustment were the "business of insurance" activities considered to be most threatened by the antitrust laws. See, e.g., section 4(b) of the original NAIC Bill, reprinted at 90 Cong. Rec. A4406 (Nov. 16, 1944). Insurance company rating bureaus supervised by state insurance departments in particular were Congress' main concern. See, e.g., *SEC. v. National Securities, Inc.*, 393 U.S. 453, 458 (1969) & 91 Cong. Rec. 1481 (Sen. Ferguson). The "business of insurance" had a plain and straightforward meaning at that time because insurance was a self-contained business operating largely on the basis of actuarially determined costs beyond their control. As a House Report on the total exemption bills stated:

> The theory of insurance is the distribution of risk according to hazard, experience, and the laws of averages. These factors are not within the control of insuring companies in the sense that the producer or manufacturer may control cost factors. [H. R. Rep. 873, 78th Cong., 1st Sess. 8-9 (1943).]

Congress never considered the issue of trade restraints imposed outside the insurance business, let alone state insurance department regulation of inter-industry restraints of trade.

Nor did Congress ever consider the novel Blue Cross and Blue Shield plans, which were then in their infancy and distinct from traditional forms of insurance: [11]

> [11] R. Eilers, *Regulation of Blue Cross and Blue Shield Plans* 13 (1963) (the same was true for the later Blue Shield plans, *id.* at 80-95). The Blues were also distinct from traditional insurers in that they were controlled by doctors and hospitals.

> From their early beginnings, and to the present day, Blue Cross plans and insurance companies have taken divergent approaches to the problem of protecting against medical care expenses. As one example, Blue Cross has employed "service-type" benefits while insurance companies have sold "cash-indemnity" policies.

The Blues' distinctive "service-type benefits" were rendered through participating provider contracts like those involved in this case. These unique arrangements were so new and so different from traditional forms of insurance that they, let alone their anticompetitive effects on medical markets, were never considered by Congress.

Indeed, the insurance industry held coverage for medical expenses as sold by the "Blues" in "complete. . .disdain" and did not consider it "insurance." Eilers, *supra,* at 13. The "Blues" themselves vigorously argued that they were not insurance but "medical prepayment plans" in order to avoid state insurance regulation and taxation. [12] And the majority of state courts considering the issue have held the Blues are not "insurance." *Id.*

Petitioners spend nearly one third of their argument trying to show that Blue Shield policies are "insurance" without making the slightest reference to this adverse precedent and history. Pet. Brief 20-27. Apparently desperate to show that Blue Shield was "insurance" and that trade restraints imposed on non-insurance markets were considered by Congress, Petitioners invoke Attorney General Biddle's testimony regarding the *American Medical Association* case that health maintenance organizations are a form of insurance. The Petitioners' convoluted argument simply misses the mark. First, the HMO in the *AMA* case was held *not* to be a form of "insurance." *Jordan v. Group Health Assn.*, 107 F. 2d 239 (1939). Second, Congress never addressed in the *AMA* context or anywhere else the profound issues here concerning inter-industry trade restraints. Attorney General Biddle's remarks were solely used to justify the *S.E.U.A.* indictments prior to the Supreme Court's decision in that case.

> [12] See generally Denenberg, "The Legal Definition of Insurance," 30 J. Insurance 319, 322 (1963). See also Peart & Hassard, "The Organization of California Physicians' Service," 6 *L. & Contem. P.* 565, 569-71 (1939) (California's was the first Blue Shield plan) & Starkweather, "Regulation of Health Insurance: A Review," 27 *Medical Care Rev.* 335 (1970).

The unique nature of Blue Shield plans and the considerable authority holding that they are not a form of "insurance" is sufficient under rulings by this Court to hold the McCarran Act inapplicable to petitioners. *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1973). It would be both ironic and unjust to provide McCarran Act protection to Blue Shield plans that sought to avoid the very insurance department taxation and regulation the McCarran Act was passed to preserve. Alternatively [13], the novelty of Blue Shield plans and their non-insurance status at the time of the McCarran Act's passage underscores the conclusion that the "business of insurance" had a plain meaning to Congress with distinct boundaries -- the insurance industry. Trade restraints imposed on non-insurance businesses such as pharmacies were never understood to be part of the "business of insurance."

C. While Congress Recognized The Expertise of State Insurance Departments To Regulate The Insurance Industry It Never Deferred To Their Authority Or Expertise In Regulating Non-Insurance Businesses

Operating from the basic principle that express or implied "exemptions from antitrust laws are strictly construed," [14] this Court has refused to extend antitrust exemptions in directly analogous contexts involving other regulated industries. Even though an exemption applies in whole or in part to activities of a firm in a regulated market the Court has not extended the exemption to other markets with which the firm does business. See, e.g., *Otter Tail Power Co. v. U.S.*, 410 U.S. 366 (1973) and *Cantor v. Detroit Edison Co.*, 428 U.S. 579, 596, (1976). Antitrust laws have been applied in relationships with both customers or suppliers even though a regulatory exemption exists at one of the horizontal levels. See, e.g., *Otter Tail, supra and Poller v. Columbia Broadcasting System, Inc.*, 368 U.S. 464 (1962).

13 The two issues are distinct, since activities related to an "insurance" product need not be within the "business of insurance." See *SEC v. National Securities, Inc.*, 393 U.S. 453, 459-60 (1969). The inapplicability of the McCarran Act on either ground would still permit state regulation to provide antitrust immunity under the *Parker v. Brown* doctrine. For sake of argument, it will be assumed that Blue Shield policies are "insurance" for the duration of this brief.

14 *Fed. Maritime Comm. v. Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973).

Similarly, the antitrust laws have been applied to relations between regulated industries, such as trucks and railroads, radio and television, and banks and savings and loan associations, so that inter-industry competition is maintained even though intra-industry competition is dampened by regulation. See generally L. Sullivan, *Handbook of the Law of Antitrust* 745-46 (1977).

A recent Ninth Circuit decision has incisively analysed these issues in a manner directly applicable to the instant case. *Foremost International Tours, Inc. v. Quantas Airways Ltd.*, 525 F. 2d 281 (1975), cert. denied 429 U.S. 816 (1976), involved allegations that Quantas Airlines acted outside the regulated air carrier industry and monopolized the tour industry. Sharply distinguishing the case where the anticompetitive effects are confined to the regulated industry, the Court held that Quantas was not entitled to federal antitrust immunity for anticompetitive conduct imposed outside the regulated industry:

> In this case, while the CAB has authority over Quantas, and arguably has the means to enforce an order against Quantas should it so choose, in lacking authority over all the parties, it cannot make the accommodations and effect the compromises which are the hallmark of agency regulation. It may well lack the means to deal with the total problem. But more importantly, *the regulatory agency here also lacks the expertise and the incentive (--after all it is not its industry--) to act on an inter-industry problem. There is the danger that in cases such as this the regulatory agency might favor its own regulated industry at the expense of non-regulated commerce, or at the very least, might consider the resolution of such matters to be of a less pressing priority.* [525 F. 2d at 285. (Emphasis added.)]

Sound statutory construction and a parity of reasoning and policy requires a similar interpretation of the McCarran Act under the facts in this case. State insurance departments only have the authority, expertise, and incentives to regulate the insurance business. In passing the McCarran Act, Congress never recognized any special ability of state insurance departments to regulate pharmacies, auto repair shops, hospitals, dentists, doctors or lawyers. Nor did Congress ever intimate that the special needs of the insurance industry transcended that business and must include the ability to restrain trade in any other sectors of

the economy. Indeed, as suggested in *Quantas,* there is a real danger that state insurance departments not only lack the authority and expertise to regulate other businesses, they are apt to favor the parochial interests of their industry at the expense of others. Trade restraints on non-insurance businesses, for example, might be viewed favorably if they added to the stability and financial security of an insurer. [15] The "business of insurance" should be restricted to its plain meaning and inter-industry trade restraints involving departments should be tested under *Parker v. Brown,* not McCarran Act, standards.

Petitioners' principal argument for a virtually unlimited rendering of the "business of insurance" is based on a myopic reading of this Court's *National Securities* opinion. Their note by note rendition of words in that opinion -- "type of policy," "reliability and enforcement," "status as a reliable insurer" -- produces a dissonant reading of the McCarran Act. Reduced to its essence, they ask this Court to grant insurers and to anyone who acts in concert with them a "Midas touch" in the form of monopoly privileges over any industry they come in contact with. Under Petitioners' boundless concept of the "business of insurance," insurers and their cohorts would have monopoly privileges whenever a non-insurance business affects insurance policies or rates. [16] Since every expense of operating an insurance company necessarily affects insurance rates, it is doubtful that even the pen, pencil and paper clip industries would escape

15 As the Court recently stated in an analogous context:

> If municipalities were free to make economic choices counseled solely by their own prochial interests and without regard to their anticompetitive effects, a serious chink in the armor of antitrust protection would be introduced at odds with the comprehensive national policy Congress established. *[City of Lafayette v. La. Power & Light Co.,* 55 L. Ed. 2d 364, 379-80 (1978) (Footnote omitted.)]

16 The McCarran Act's "state regulation" requirement as construed by the lower courts does not change or diminish the breadth of this proposition. "[I]n no case has it been decided that the exemption was inapplicable because of a failure of state regulation." *Ohio AFL-CIO v. Ins. Rating Bd.,* 451 F.2d 1178, 1183 (6th Cir. 1971). Although this Court can and should tighten the "state regulation" requirement consistent with Congreaaional purposes, see Weller, *supra,* the "business of insurance" should not be extended beyond its Congressionally intended plain meaning.

Petitioners' claimed monoply prerogatives. Yet there is not a shred of evidence that Congress intended to confer monopoly privileges on insurers and their cohorts to run roughshod over any industry with which they do business.

Similarly, there is no support for such a contention in this Court's *National Securities* opinion. The "business of insurance" dicta there simply mirrors Congressional understanding of the "business of insurance" with its roots in the S.E.U.A. litigation:

> Certainly the fixing of rates is part of this business; that is what South-Eastern Underwriters was all about. The selling and advertising of policies, ...and the licensing of companies and their agents. . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement -- these were the "core" of the "business of insurance." [393 U.S. at 460.]

There is nothing in the Court's language that deviates from the Congressional concept of a wholly intra-insurance industry application.

Petitioners' effort to expand the Court's unequivocal focus on the insurer-insured relationship to the insurer-*supplier*-insured relationship is further refuted later in the opinion. In upholding the concurrent application of federal securities laws and state insurance regulation to the merger of two insurance companies, the Court explained:

> [T]he remedy the [Securities and Exchange] Commission seeks does not affect a matter predominantly of concern to policyholders alone; the merger is at least as important to those owning the companies' stock as it is to those holding their policies. [*Id.* at 463.]

The Court thus held that the McCarran Act was aimed at preserving state regulation of the "business of insurance" that "predominantly concern[s] policyholders alone," and that different principles apply when the activity is of equal importance to non-policyholders. Since trade restraints imposed on industries outside insurance are at least of equal importance to those industries as to policyholders, Petitioners have mistakenly relied upon *National Securities* for the near blanket antitrust exemption they seek. Accord *Zelson v. Phonix Mutual Life Ins. Co.,* 549 F. 2d 62 (8th Cir. 1977).

Hence the "business of insurance" should be limited to its ordinary meaning and not extended to businesses Congress never considered state insurance departments authorized or qualified to regulate.

D. Regulation of Blue Shield's Pharmacy Policies By the Texas State Board of Insurance Is Confined To the Insurer-Insured Relationship and Does Not Implement Any State Policy To Suppress Competition In the Pharmacy Market.

Regulation of Blue Shield's prescription drug policies by the Texas State Board of Insurance constitutes traditional insurance regulation directed at the insurer-insured relationship and does not manifest a state policy to restrain trade in the competitive retail drug market.

The keystone in Petitioners' attempt to show a state commitment to suppressing competition in the pharmacy market is the Texas provision for the prior approval of health insurance policies. Pet. Brief 31-35. In their zeal to find a state policy where none exists, they have misconstrued the purpose of prior approval provisions and are betrayed by their own argument. Policy approval provisions are a traditional form of insurance regulation aimed at protecting policyholders by standardizing complex insurance policies. See generally R. Keeton, *Basic Text on Insurance Law* 68-73 (1971). Texas initially rejected Blue Shield's participating pharmacy program solely because of its impact on policyholders, or in Petitioners own words, because of its *"alleged discrimination between insureds* who patronized participating pharmacies and those who patronized non-participants." Pet. Brief 33-34. (Emphasis added.) In a remarkable display of alchemy, Petitioners claim that protecting policyholders is "similar" to protecting competition in the pharmacy market. *Id.* at 34. Neither the original disapproval or

the later approval of Blue Shield's pharmacy program by the Texas State Board of Insurance manifested a state policy to suppress competition in the pharmacy market.[17]

17 Petitioners' attempt to bolster their position by citing both the state's antitrust law and unfair competition provision to argue that anticompetitive effects on non-insurance markets were mandated by the state. Petitioners' reliance on these antitrust laws is misplaced. First, it appears from Petitioners' own account that the State of Texas did not consider any antitrust violation to be involved, as evidenced by the Attorney General's inaction. Pet. Brief 34 n. 30. The State certainly could not compel anticompetitive conduct when it considered none to be present. Indeed, the insurance code's unfair methods of competition provision is confined to the business of insurance and does not encompass trade restraints in non-insurance businesses as alleged here. Second, the McCarran Act applies to insurance regulation and was not intended to confer upon the States exclusive antitrust jurisdiction over the insurance industry, let alone non-insurance industries doing business with insurers. State antitrust laws patterned on the federal antitrust laws, such as Texas' unfair methods of competition provision and general antitrust law, are not "statutes aimed at protecting. . .[the insurer-insured] relationship" and therefore are irrelevant to the McCarran Act. *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969). Cf. *FTC v. National Casualty Co.*, 457 U.S. 560 (1958), where precisely the kind of insurance regulatory law covered by the McCarran Act was involved -- prohibiting insurers from using deceptive practices with insureds. Even if state antitrust laws were within the McCarran Act's reach, the fundamentally federalist purpose and specific section 2(b) standards of the Act call for *concurrent* federal and state antitrust authority. Federal antitrust laws hardly "invalidate, impair, or supersede" state antitrust laws patterened on their federal counterparts. The lower court cases to the contrary cited by Petitioners lack supporting analysis and violate the McCarran Act's purposes and this Court's precedent. See Weller, "To Preempt or To Accommodate: The Question of State and Federal Antitrust Laws Under the McCarran-Ferguson Act, *Toledo L. Rev.* (forthcoming).

This Court has already held that the mere approval of conduct not compelled by state policy is insufficient to trigger McCarran Act immunity from federal law. In *National Securities*, the Arizona insurance comissioner approved a merger between two insurance companies as having no adverse impact on policyholders. Applying the McCarran Act's federalist purposes, this Court held that the state insurance department's approval of the merger was not "invalidated, impaired, or superseded" by the concurrent application of federal securities laws:

> Arizona has not commanded something which the federal government seeks to prohibit. It has permitted respondents to consummate the merger; it did not order them to do so. [393 U.S. at 463.]

The federalist nature of the McCarran Act, recognized in *National Securities*, similarly applies here. See n.9, *supra*. Texas' approval of Blue Shield policies for their impact on *policyholders* is not impaired by the concurrent application of the federal antitrust laws for their impact on the pharmacy market.

The analogy of the instant case to this Court's recent *Cantor v. Detroit Edison Co.*, 428 U.S. 579 (1976) ruling on the *Parker* doctrine is striking and should be controlling. [18] There, as here, the defendant allegedly devised and imposed an anticompetitive scheme on an unregulated market. There, as here, the defendant claimed antitrust immunity because a state agency regulating one industry had purportedly "approved" the

18 The analogy of the *Parker v. Brown* doctrine involved in *Cantor* is especially strong since there is significant evidence that, as the NAIC put it, the McCarran Act's "Section 2(b) is essentially an enunciation of the *Parker v. Brown* decision." NAIC, *Monitoring Competition* 27 n. 58 (1974).

Apparently deeply troubled by the close relation of the *Parker* doctrine and McCarran Act section 2(b), Petitioners try valiantly to distinguish the two. Pet. Brief 17-19 n. 14. They even go so far as citing Senate Report 1112 and House Report 873, which related to the rejected total exemption bills and not to the fundamentally different NAIC Bill, S. 340, upon which the McCarran Act is based. The proviso clause in section 2(b) of the Act is strikingly similar to the *Parker* doctrine and could well have formed the basis for the compromise between the House and Senate versions of S. 340. See n.9, *supra* and Weller, *supra* n.4.

defendant's private proposal impacting on an unregulated market. [19] In holding no antitrust exemption was appropriate, this Court articulated a rationale that goes to the heart of this case:

> The Commission's approval of respondent's [Detroit Edison] decision to maintain such a program [providing free light bulbs] does not . . .implement any statewide policy relating to light bulbs.
>
> *There is no logical inconsistency between requiring . . . a [regulated] firm to meet regulatory criteria insofar as it is exercising its natural monoply powers and also to comply with antitrust standards to the extent that it engages in business activity in competitive areas of the economy.* [428 U.S. at 585, 595-96. (Emphasis added.)]

Unlike state rating bureau legislation where the state's clear intention is to substitute regulation for competition, the Texas policy approval provision, which is the keystone of Petitioners' regulation argument, does not evidence any state policy to displace competition in the essentially unregulated pharmacy market. The Texas policy approval provision is only aimed at the insurer-insured relationship, and thus further demonstrates that the alleged trade restraints imposed on the pharmacy market are beyond the "business of insurance."

E. Blue Shield's Alleged Combination With Persons Not Engaged in the Business of Insurance To Restrain Trade in The Pharmacy Market Is Not Entitled To McCarran Act Protection.

Congress' unambiguous intention of restricting the reach of the McCarran Act to the insurance industry is also expressed in Section 2(a)'s language limiting the Act to "every person engaged" in the "business of insurance." It is inconceivable that

19 Absent express immunization or its equivalent, it is generally well established that private business arrangements are not exempt from the antitrust laws merely because a regulatory agency approved them. See, e.g., *U.S. v. Radio Corp. of America*, 358 U.S. 334, 353 (1959), *California v. FPC*, 369 U.S. 482 (1962), *U.S. v. Philadelphia National Bank*, 374 U.S. 321, 350 (1963), *Otter Tail Power Co. v. U.S.*, 410 U.S. 366, 372 (1973) and cases cited in *Cantor, supra*, at 592-93 nn. 26-30.

Congress considered pharmacists to be engaged in the business of insurance. Nevertheless, Petitioners would have this Court rewrite the McCarran Act to deal with claimed changed circumstances. As Mr. Justice Harlan has observed, a statute "is not an empty vessel into which this Court is free to pour a vintage that we think better suits present-day tastes." *U.S. v. Sisson*, 399 U.S. 267, 297 (1970).

Faced with section 2(a)'s express exclusion of pharmacists from the McCarran Act, Petitioners rely on inapposite analogies in an attempt to find ambiguity where there is none. Petitioners incorrectly argue that conduct and not the identity of the parties is used to determine the scope of statutory antitrust exemptions. Pet. Brief 36-37. The law is clear, however, that the statute controls whether conduct, the parties, or both are relevant to determining the scope of an antitrust exemption. As the Court's recent decision in *National Broiler Marketing Assn. v. U.S.*, 46 U.S.L.W. 4620 (June 13, 1978), dramatically illustrates, the identity of the parties can be decisive to the applicabilty of an antitrust exemption. There Capper-Volstead immunity was not appropriate because certain persons were not "farmers" as required by the statute. Similarly, McCarran Act immunity is inapplicable here because pharmacists are not "persons engaged" in the "business of insurance" as required by the Act.

The District Court's opinion in this case is the first ruling in the McCarran Act's 31 year history that persons not engaged in the insurance business, pharmacists, are nonetheless entitled to the Act's antitrust exemption. This unwarranted extension of the McCarran Act means that an insurer could combine with anybody in virtually any industry to restrain trade outside the insurance business. It is wholly at odds with Congress' unambiguous language and purpose of limiting the McCarran Act to the "business of insurance" alone.

As in other areas where normally exempt entities combine with non-exempt entities to restrain trade in non-exempt markets, Congressional intentions require this Court to deny all Petitioners McCarran Act protection. See, e.g., *Allen Bradley Co. v. Local 3, IBEW*, 325 U.S. 797 (1945) (labor exemption) and *National Broiler Marketing Assn. v. U.S., supra*, (agricultural cooperatives exemption). Accord *Hill v. National Casualty Co.*, 1971 Trade Cases paragraph 73, 594 (N.D. Calif.).

II.

Cost Containment Measures By Health Insurers And By State Insurance Departments Will Flourish Without McCarran Act Protection

Petitioners and several *amici curiae* have gone to great lengths predicting the demise of state insurance department regulation of health insurance and of aggressive cost containment by health insurers if the "business of insurance" language of the McCarran Act is not interpreted to immunize inter-industry restraints of trade. Petitioners passionately proclaim that the states will be "effectively prevent[ed] . . . from fostering the use of cost containment measures..." and that "insurers could no longer employ any method . . . of keeping health insurance premiums down by containing health care costs." Pet. Brief 39. These doomsday prophecies are completely unfounded in law and fact.

First, aggressive cost containment measures by a health insurer need not violate the antitrust laws. As the Blue Shield Association's ("BSA") *amicus* brief shows, it is doubtful that the participating pharmacy contract actually violates the antitrust laws. BSA Brief 28-35. The U.S. Department of Justice found no antitrust violations in similar programs after an extensive analysis. Third Party Prepaid Prescription Drug Programs: *Hearings Before The Subcomm. on Environmental Problems Affecting Small Bus., H. Select Comm. on Small Bus.*, 92d Cong., 1st Sess., 227 (1971) (testimony of Bruce Wilson) & BSA Brief. App. D-F. The Texas Attorney General saw no antitrust violation. Pet. Brief 34 n.30.

At least three courts have ruled specifically that similar health care cost containment measures do not violate the antitrust laws. *Webster County Memorial Hosp., Inc. v. United Mine Workers*, 1976-1 Trade Cases paragraph 60, 896 (D.C. Cir.); *Anderson v. Medical Service of D.C.*, 1976-1 Trade Cases paragraph 60, 884 at 68, 857-58 (E.D. Va.), aff'd. mem. 551 F. 2d 304 (4th Cir. 1977) and *Travelers Ins. Co. v. Blue Cross of W. Pa.*, 481 F.2d 80, 84 (3d Cir. 1973). Notwithstanding the Fifth Circuit's dicta to the contrary in *Royal Drug Co. v. Group Life & Health Ins. Co.*, 556 F.2d 1375, 1382 (1977), the suggestion that that antitrust laws impose a passive role on health insurers is simply incorrect. As the Third Circuit observed in *Travelers*, the antitrust laws promote and do not prohibit health insurer cost containment:

> *In its negotiating with hospitals, Blue Cross has done no more than conduct its business as every rational enterprise does, i.e., get the best deal possible.* This pressure encourages hospitals to keep their costs down; and, for its own competitive advantage, Blue Cross passes along the saving thus realized to consumers. To be sure, Blue Cross' initiative makes life harder for commercial competitors such as Travelers. The antitrust laws, however, protect competition, not competitors; and stiff competition is encouraged, not condemned. [481 F. 2d at 84. (Emphasis added.)]

It is true health care providers can be expected to resist cost containment initiatives of private health insurers by filing dubious antitrust cases and by taking other action. This Court has never expanded antitrust exemptions simply because unhappy plaintiffs may be filing non-meritorious antitrust cases, and should not do so now.

Furthermore, the threat of these lawsuits will not eliminate insurer cost containment as Petitioners and several *amici* predict. The tremendous market demand today for insurer cost containment evidenced by the numerous *amici* briefs filed by employers and unions poignantly demonstrates that health insurers will continue to provide a wide range of cost controls that do not violate the antitrust laws.

On the other hand, it is conceivable that some insurers may go too far and monopolize or restrain trade in health care markets. In such instances, nothing in the McCarran Act nor sound public policy mandates that health care providers should be victimized by truly monopolistic practices. There are many things insurers can do to contain costs without violating the antitrust laws.

Second, since the McCarran Act was solely intended to cover state insurance department regulation of the insurance business, it is not applicable to Petitioners and the Texas State Board of Insurance. At the same time *Parker v. Brown*, 317 U.S. 341 (1941) and its progeny make abundantly clear that states may use their insurance departments or other regulatory agencies to substitute regulation for competition in most businesses -- insurance, pharmacy, hospital or others -- without disruption or preemption by the federal antitrust laws. For example, in *Frankford Hospital v. Blue Cross of Greater Philadelphia*, 554 F. 2d

1253 (3d Cir. 1977), Pennsylvania compelled Blue Cross to contain hospital costs in a manner alleged to violate the antitrust laws. In that case *Parker* immunity for Blue Cross would have been appropriate.

If states choose to regulate other businesses through their insurance departments, then the *Parker* doctrine rather than the McCarran Act provides the proper standard for determining antitrust immunity and certainly protects state initiated programs to contain the rapidly increasing costs of health care.

CONCLUSION

The Fifth Circuit's decision interpreting the "business of insurance" should be affirmed. Extending the McCarran Act to immunize an alleged Blue Shield-pharmacy conspiracy to restrain the pharmacy market would violate Congress' unmistakable intention of confining the Act to the insurance business and those engaged in it. It would also be unnecessary, since the *Parker* doctrine and ordinary antitrust principles fully promote and protect legitimate cost containment efforts by health insurers and the states.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, et al.,
Petitioners,
v.
ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, et al.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR AMICUS CURIAE PHARMACISTS GUILD OF MICHIGAN

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On Writ of Certiorari to the United States
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BRIEF FOR AMICUS CURIAE PHARMACISTS GUILD OF MICHIGAN

This brief is filed on behalf of the Pharmacists Guild of Michigan with the written consent of all parties to this proceeding pursuant to Rule 42 of the Court.

THE INTEREST OF THE AMICUS CURIAE

The Pharmacists Guild of Michigan (Pharmacists Guild) is a voluntary, nonprofit membership association composed of approximately 250 small independent pharmacists located throughout the State of Michigan. Most of its members are faced with doing business under a prepaid prescription plan substantially identical to the one condemned by the Fifth Circuit Court of Appeals in the instant controversy.

The Fifth Circuit Court of Appeals has held that price fixing in a prescription plan does not constitute the "business of insurance" and does not focus on the relationship between the insurer and the policyholder. Price fixing, regardless of its context, is a per se violation of Section 1 of the Sherman Act, 15 U.S.C. § 1 (1970).

The Pharmacists Guild is vitally interested in fostering a free and open, competitive pharmaceutical market. The price fixing and boycott activities of Petitioners herein, if protected from antitrust scrutiny, would drive the small, service oriented independent pharmacist out of business in Texas, a result not contemplated or intended by the authors of the McCarran-Ferguson Act. The public would otherwise be faced with having to accept the prices of pharmaceuticals dictated by the few large pharmacy chains. The small independent pharmacist in Michigan is faced with substantially identical price fixing and boycott activities and accordingly has a personal interest in the outcome of this litigation.

SUMMARY OF ARGUMENT

Petitioners herein are seeking to exempt their price fixing and boycott activities from antitrust review by virtue of the McCarran-Ferguson Act (hereinafter referred to as the "McCarran Act"). The Courts have held that the McCarran Act must be strictly construed, and the Petitioners in seeking its application have the burden of demonstrating that the activities at issue (a) are in the "business of insurance" and (b) are regulated by "State law". Petitioners have failed to meet this burden. The McCarran Act has no application in this case.

The courts have defined the "business of insurance" concept narrowly, holding that it only applies to activities which are *peculiar* to the insurance industry and actions which primarily involve the relationship between the insurance company and its policyholders. The price fixing and boycott activities of Petitioners are not peculiar to the insurance industry. Nor do the challenged activities of Petitioners involve the relationship between Petitioner Blue Shield and its policyholders. The price fixing and coercion herein primarily involve relationships between competing pharmacies and between pharmacies and their customers. Petitioner Blue Shield's *sole obligation* to its policyholders is to supply pharmaceuticals and to ensure that its subscribers pay no more than the drug deductible. So long as policyholders only pay the drug deductible, they are basically unconcerned with arrangements made between Blue Shield and the pharmacies.

Petitioners' argument that the "type of policy", its feature of providing "goods and services benefits" instead of cash indemnification, and its purpose to contain claims costs, is not available. This argument does not transform Petitioners' price fixing and boycott activities into the "business of insurance". The "goods and services benefit" herein is the providing of pharmaceuticals and *not* the fixing of their prices. Furthermore Blue Shield's alleged purpose to contain claims costs does not make the challenged activities the "business of insurance". The Congress and the courts have consistently held for decades that price fixing is a per se violation of the Sherman Act, regardless of its reasonableness or noble purpose.

Any argument that the challenged activities of Petitioners constitute the "business of insurance" because they lower rates which in turn have a favorable impact on Blue Shield's "status as a reliable insurer" must also fail. Any activity which increases the profits of an insurance company enhances its reliability and solvency. As this Court found in *SEC* v *National Securities, Inc.*, 393 U.S. 453 (1969), the mere fact that an activity makes an insurance company more financially reliable does not dictate that such activity constitutes the "business of insurance".

Petitioners have also failed to show that their challenged activities are regulated by *State law*. Their price fixing and boycott actions clearly were not regulated by Texas law. Petitioners argue that a plan "identical" in concept to the plan at issue herein was approved by the Attorney General for the State of Texas in 1962. Approval by the State Attorney General cannot amount to regulation by *State law*. In any event the plan

approved by the Attorney General did not contain any price fix or boycott mechanisms. The Attorney General approval only covered the mechanics and administration of the plan.

It is also clear from the record in this case that the Texas State Board of Insurance *did not* approve the Pharmacy Agreement at issue. On deposition, a responsible official from the State Board of Insurance stated that the agreement was not within the regulatory control of the State Board. This fact that the State of Texas has declared that the Pharmacy Agreement is outside its regulatory control is significant, because it uncontestably demonstrates that there is *no conflict* between state insurance regulation and federal antitrust enforcement in this case. A primary purpose behind the passage of the McCarran Act was to preserve from federal interference the state's traditional role of regulating the "business of insurance". As conceded by the State of Texas, there is no State regulation to protect in this case. The McCarran Act accordingly has no application herein.

For these reasons, and for the reasons set forth in detail herein, the judgment of the Fifth Circuit Court of Appeals should be affirmed.

ARGUMENT

Introduction

Petitioners ask the Court to find that certain activities are immunized from antitrust scrutiny by virtue of the McCarran Act. That Act provides a statutory exemption to actions which would normally be subject to antitrust

liability. Statutes like the McCarran Act "are to be construed strictly". *Abbott Labs.* v *Portland Retail Druggists Ass'n., Inc.*, 425 U.S. 1, 11 (1976). Any laxity in finding exemptions from antitrust laws has been rebuked by this Court with the observation that " '[O]ur cases have repeatedly established . . . a heavy presumption against implicit [antitrust] exemptions.' " *Abbott Labs.* v *Portland Retail Druggists Ass'n., Inc.*, 425 U.S. 1, 12 (1976) (brackets in original), quoting *Goldfarb* v *Virginia State Bar*, 421 U.S. 773, 787 (1975). Those who would invoke the McCarran Act exemption accordingly shoulder a heavy burden of clearly demonstrating its application.

The McCarran Act is narrow in scope. Only actions or activities in the "business of insurance" that are regulated by State law attain exempt status. Section 2(b) of the Act provides:

> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, . . . unless such Act specifically relates to the business of insurance: *Provided*, That . . . the Sherman Act, . . . the Clayton Act, and . . . the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by *State law*. (emphasis supplied) 15 U.S.C § 1012(b).

The Act accordingly has no application where the activities at issue are either (a) not in the "business of insurance" or (b) even if the activities are in the

"business of insurance," they are not regulated by "State law". For Petitioners to prevail, their challenged activities must be:

(1) legitimately in the *"business of insurance"; and*

(2) regulated by *State law*.

Neither standard is met. The Judgment of the Fifth Circuit Court of Appeals finding the McCarran Act inapplicable should be affirmed.

I.

BECAUSE THE CHALLENGED ACTIVITIES ARE NOT IN THE BUSINESS OF INSURANCE, SUCH ACTIVITIES ARE NOT PROTECTED FROM ANTITRUST ENFORCEMENT BY TH McCARRAN ACT.

a. The Challenged Activities of Petitioners are Not Peculiar to the Insurance Industry and Do Not Directly Involve the Relationship Between Blue Shield and Its Policyholders.

1. The McCarran Act protects only those actions which are legitimately in the "business of insurance". This Court in *SEC* v *National Securities, Inc.*, 393 U.S. 453, 459-460 (1969), warned that McCarran Act immunity is narrow, holding that it encompassed only the *business of insurance* and not all activities of insurance *companies* per se:

> The statute did not purport to make the States supreme in regulating all the activities of insurance *companies*; its language refers not to

> the persons or companies who are subject to state regulation, but to laws "regulating the *business* of insurance." Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the "business of insurance" does the statute apply. (emphasis by the Court).

The Court reasoned that only those activities which primarily involve the insurance company's dealings with its policyholders are in the "business of insurance":

> The McCarran-Ferguson Act was an attempt to turn back the clock, to assure that *the activities of insurance companies in aealing with their policyholders would remain subject to state regulation*. 393 U.S. at 459. (emphasis supplied).

Emphasizing this thrust of protecting the insurance company's dealings with its policyholders, the Court announced that the primary protective focus behind the McCarran Act was *the relationship between the insurance company and its policyholders*:

> But whatever the exact scope of the statutory term [business of insurance], it is clear where the focus was — it was on the relationship between the insurance company and the policyholders. 393 U.S. at 460.

Accord, DeVoto v *Pacific Fidelity Life Insurance Co.*, 516 F.2d 1 (9th Cir. 1975) (activities peripheral to the insurance company-policyholder relationship held not to constitute the "business of insurance".) The Court decided that because the challenged activities primarily involved the relationship between stockholders and the

company that owned the stock, and *not* the relationship between the insurance company and its policyholders, there was no McCarran Act exemption.

2. The Fifth Circuit in the present case followed this definition of McCarran Act immunity. It was decided that the price fixing and coercive boycott activities at issue were not *peculiar* to the insurance industry. In so holding, the Court emphasized that such activities could just have easily been undertaken by *noninsurance entities:*

> Moreover, business activities of insurance companies not peculiar to the insurance industry are outside the scope of the McCarran Act [citations omitted]. As indicated by the activities of the insurance company in *Manasen, supra, the activity complained of by plaintiffs is not peculiar to the insurance industry. To be sure, price fixing and coercion induced by firms with superior bargaining power are often found in all industries. Thus, Blue Shield's attempts to control costs in the pharmaceutical industry might just as easily be undertaken by a noninsurance firm attempting to meet a contractual obligation to deliver drugs to a wholesale or retail customer.*(emphasis supplied).[1] 556 F.2d at 1386.

Accord, American Family Life Assurance Co. v *Planned Marketing Association*, 389 F. Supp. 1141 (E.D. Va.

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[1] The Court of Appeals elsewhere in its Opinion underscored this point. For example, the Court at 1382 stated that "We find that the Pharmacy Agreement goes beyond Blue Shield's obligations as an insurer and places the firm in the business of providing products and services".

1974); *Center Ins. Agency, Inc.* v *Byers*, 1976-1 Trade Cas. Paragraph 60,940 (N.D. Ill. 1976); *American General Ins. Co.* v *FTC*, 359 F. Supp. 887 (S.D. Tex. 1973), *aff'd.* 496 F.2d 197 (5th Cir. 1974). Petitioners' price fixing and coercive boycott activities can hardly be claimed as *peculiar* to the business of insurance. The Court in *Hill* v *Nat'l. Auto Glass Co., Inc.*, 293 F. Supp. 295, 296 (N.D. Cal. 1968), faced with similar boycott activities utilized a common sense approach when it held that:

> . . . it does not seem . . . that the alleged activity involved here, namely securing for particular glass dealers the sales and installation jobs required by Allstate claimants, is a part of the "business of insurance" as that term is normally understood.

Likewise, the subject price fixing and coercive boycott activities are not indigenous to the insurance industry.

3. Nor do the activities at issue involve dealings between Blue Shield and its policyholders. At best, they only remotely involve the insurance company-policyholder relationship. As noted by the Fifth Circuit, Blue Shield's sole obligation to its policyholders is to see that they receive prescription drugs and pay no more than the drug deductible for such covered drugs.[2] So long as policyholders only have to pay the drug deductible, they are unconcerned with any arrangements made between Blue Shield and the Pharmacies.

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[2] It is important to remember that this obligation is self-imposed. Petitioners designed the policy at issue. It was not forced to include specific terms and conditions.

The relationships primarily involved are among *competing pharmacies*. The discrimination in reimbursement is between *competing pharmacies* and is designed to coerce subscribers to deal only with retailers who agree to the price fix. Such discrimination also coerces *pharmacists* to agree to the price fix.

The challenged activities of Petitioners extend far beyond the insurance company-policyholder relationship. This conclusion is buttressed by examining what effects the challenged activities would have on other sectors of the economy. As discussed by the Court below, if the challenged actions somehow constituted the "business of insurance", automobile insurers would be able to utilize "Participating Construction Company Agreements" and thereby combine and conspire with large construction companies to set the prices for the repair and rebuilding of homes or buildings damaged by fire. These same companies would also be able to execute participating agreements with large department stores and thereby endeavor to set prices at which insureds would replace televisions, stereos, furniture and articles destroyed by fire. Hardly a sector of our economy would be free from price fixing activities of insurance companies if the activities challenged herein are immune from the federal antitrust laws.

b. Petitioners' "Type of Policy" and "Reliability" Arguments Attempting to Show that Their Challenged Activities Constitute the "Business of Insurance" Must Fail.

1. Petitioners in their Brief make a variety of imaginative arguments to reverse the finding of the Fifth Circuit. Relying on language from *National*

Securities, Inc., Petitioners initially argue that the "type of policy", its feature of providing for "goods and services benefits" rather than offering cash indemnification exclusively, and its "purpose" to contain claims costs, constitute the "business of insurance".[3] (Brief for Petitioners, p. 24) This contention must be rejected. The specific "goods and services benefit" provided for in the instant controversy is pharmaceuticals. Petitioners herein are fixing the retail sales prices between competing pharmacies for this "goods and services benefit". The "benefit" to the subscriber is the providing of the pharmaceutical, not the setting of its price. Blue Shield's sole obligation to its subscribers under the Prescription Drug Insurance Policy is not to fix prices for pharmaceuticals but merely to provide them. The price fixing aspects of Blue Shield's policy therefore do not constitute the "business of insurance". Otherwise insurance companies would be able to fix the prices of every other "goods and services benefit" related, however remotely, to the administration of their insurance policies.

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[3] To show "business of insurance" in this case, Petitioners almost entirely rely on language in the *National Securities, Inc.* case at 393 U.S. 460 in which the "type of policy" and whether activities relate closely to an insurance company's *status as a reliable insurer* were mentioned as concepts to use in determining whether an action fits the statutory term.

2. Nor can the alleged purpose, i.e., containing claims costs for the public's benefit, behind the policy at issue, however meritorious and public spirited, transform the challenged activities into the "business of insurance". It is conceivable that the public might benefit from price fixing arrangements so long as the parties to the agreements agree to keep their prices reasonable.[4] However, Congress and the courts have steadfastly adhered to the proposition that price fixing is a per se violation of the Sherman Act, regardless of its apparent reasonableness or purpose. This longstanding principle was recently affirmed in *National Society of Professional Engineers* v *United States*, 46 U.S.L.W. 4356 (April 25, 1978). There it was held that significant public policy arguments could not make legal under the Sherman Act an absolute ban on competitive fee bidding found to be anticompetitive "on its face". Likewise, Blue Shield's purported public interest motivation cannot be the bootstrap to lift the elimination of price competition to a protected status under the McCarran Act.

3. Petitioners also argue that their activities are in the "business of insurance" because their "cost containment" efforts lower subscriber rates which in turn have a favorable impact on Blue Shield's *"status as a reliable insurer"*. This contention must also be rejected. Any activity which increases the profits of an insurance company makes that firm arguably

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[4] As the Court of Appeals aptly pointed out at 556 F.2d 1381, 1382, these "cost containment" features principally inure to the benefit of Petitioner Blue Shield, *not* the public.

more reliable as an insurer. This Court in *National Securities, Inc.* explicitly announced that the mere fact an activity makes an insurance company more financially stable, and therefore more "reliable", does not dictate that such activity is in the "business of insurance". There the Court held that the merger of two insurance companies did not constitute the business of insurance, despite the fact that the transaction directly affected the financial stability of the two companies, which in turn affected policyholders in terms of the security of their contracts and reliability of their insurers. If an activity's financial impact on an insurance company is the standard to determine whether that activity directly relates to that company's status as a reliable insurer, then virtually any type of conduct would be in the "business of insurance". Almost any activity of an insurance company, however unrelated to the business of insurance, can have a beneficial effect on subscriber rates, and therefore the company's reliability and solvency. The contention that such activity meets the "business of insurance" standard of the McCarran Act is untenable.

4. To summarize, Petitioners' "type of policy" and "reliable" insurer arguments must fail. While the "cost containment" activities of Petitioners may make Blue Shield more reliable and solvent, such actions cannot be considered the "business of insurance" because they are nothing more than a price fix on certain goods and services and a boycott of pharmacies and subscribers. Surely Blue Shield can develop "cost containment" programs which do not have such anticompetitive results in the marketplace. These activities go far beyond Blue Shield's limited obligations as an

insurance company to its policyholders and primarily involve the relationships between competing pharmacies and their customers. If such activities are countenanced as part of the "business of insurance", then insurance companies could effectively fix prices and enter into other onerous arrangements in virtually every sector of the economy. The Court of Appeals' common sense finding that the anticompetitive activities of Petitioners are not in the "business of insurance" should be followed.

II.

BECAUSE PETITIONERS' PRICE FIXING AND BOYCOTT ACTIVITIES ARE NOT REGULATED BY STATE LAW, SUCH ACTIVITIES ARE NOT PROTECTED FROM ANTITRUST ENFORCEMENT UNDER THE McCARRAN ACT.

1. The Fifth Circuit Court of Appeals not only held that Petitioners' challenged activities were not in the "business of insurance" but *also* that they were not regulated by *State law*. It was specifically decided that a key document in this litigation, the Pharmacy Agreement, was never approved by the State of Texas and was outside its regulatory control (556 F.2d at 1384-1385). Petitioners in their current Brief ask that the Fifth Circuit be reversed, contending that "The pervasive regulation of Blue Shield's arrangements with pharmacies are part of the 'business of insurance' ", (Brief for Petitioners, p. 31). Petitioners' "pervasive

regulation" contention is without merit and the Fifth Circuit should be affirmed.[5] The Petitioners' challenged activities are not regulated by the State of Texas as part of the business of insurance.

Participating pharmacists, pursuant to a Pharmacy Agreement, agree to set their retail sales prices for all pharmaceuticals to Petitioner Blue Shield's subscribers at an amount equal to the pharmacy's acquisition cost for a particular drug, plus a "professional dispensing fee" of $2.00. This is a price fixing agreement, nothing more, nothing less.[6] By markedly reducing benefits to those subscribers who patronize a pharmacy that refuses to sign the price fixing agreement, Petitioner Blue Shield is also intentionally coercing its subscribers to boycott these pharmacies.[7] This boycott also operates to coerce nonsigning pharmacies to participate in the price fix.

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[5] It should also be noted that the mere fact that a Board of Insurance may have taken some action regarding a matter does not "demonstrate" that such matter is in the "business of insurance", even assuming such action was required by *State law*. As shown in Section I herein, the two standards, "business of insurance" and "State law" are mutually exclusive and must be analyzed separately.

[6] Indeed, Petitioner Blue Shield was aware of this illegality in the Pharmacy Agreement. As noted by the Court of Appeals at 556 F.2d 1382, documents of Petitioner Blue Shield produced through discovery reveal Petitioner's concern over antitrust problems with the Pharmacy Agreement and an apparent attempt to camouflage the price fix as a "mass accounting agreement."

[7] In this instance Petitioner Blue Shield's subscribers receive only 75 percent of the "usual and customary" charge for the drug, less the $2.00 deductible.

2. These price fixing and boycott activities are not regulated by the State of Texas. The record in this case uncontestably supports this fact. Petitioners contend that their challenged actions are regulated by the State of Texas because of a 1962 Opinion of the State Attorney General approving a prepaid prescription plan "identical" in concept and operation to the one at issue herein. (Brief for Petitioners, p. 31; Fifth Circuit Opinion at 556 F.2d 1384). This Opinion is appended hereto as Appendix "A". Such approval cannot amount to the regulation by *State law* of Petitioners' price fixing and boycott mechanisms. Rather, the plan approved in the Opinion set forth a fractional amount that the insurer was obligated to pay, with the policyholder to pay the remaining fraction of the pharmacist's "prescription selling price" not set by the agreement. Obviously, no price fixing was approved by the State of Texas in this Opinion. Any prices to be computed were not part of the plan. The action of the Attorney General for the State of Texas only covered approval of the mechanics and administration of the 1962 Plan. There was no approval of price fix or boycott mechanisms by the State of Texas.

3. To show state regulation, Petitioners also contend that the Pharmacy Agreement has been approved by the Texas State Board of Insurance. (Brief for Petitioners, p. 32.) Once again there is no record whatsoever that the Board of Insurance actually approved the Pharmacy Agreement. As stated by the Court of Appeals at 556 F.2d 1384, the gentleman from the State Board of Insurance office admitted that the Pharmacy Agreement was outside the State's regulatory control:

> *It is clear from the record that the Board has never approved the Pharmacy Agreement*, and the Division Manager of the Board's Policy Approval Division, a Mr. Pogue, testified that he thought the Pharmacy Agreement was outside of the State's regulatory control. He stated as follows: *"I do not feel that a contract of that nature falls within the jurisdiction of the State Board of Insurance"*. (emphasis supplied)

Given this finding of fact, there can be no doubt that the appropriate regulatory agency for the State of Texas regards the Pharmacy Agreement at issue herein to be outside the regulatory control of the State. Petitioners' contention that the Pharmacy Agreement was approved, and therefore regulated, by the State of Texas as part of the business of insurance is erroneous and should be rejected.[8]

The State of Texas' opinion that the Pharmacy Agreement is outside the regulatory control of the business of insurance is of significance to this Court's

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[8] Even assuming that the Attorney General or the Texas State Board of Insurance gave their "approval", it would not establish that the activity was regulated by State law, unless there was some Texas statutory provision granting the Attorney General or Board of Insurance authority in this area. In addressing the second standard to determining the existence of McCarran Act application this Court in *SEC* v *National Securities, Inc.*, 393 U.S. 453, 460 (1969) stated:

> *"Statutes* aimed at protecting or regulating this relationship, directly or indirectly, are *laws* regulating the 'business of insurance' ". (emphasis supplied)

Because neither party alleged that either the Attorney General or Board of Insurance acted outside its authority, this is not an issue in the present case.

ultimate determination that the challenged activities of Petitioners cannot be protected by the McCarran Act. In *SEC* v *National Securities, Inc.*, 393 U.S. 453 (1969), this Court held that a major reason for the passage of the McCarran Act was to prevent any federal-state conflict relative to the dealings of insurance companies with their policyholders. The Act itself in Section 2(b) bespeaks of such Congressional intent with the words that no Act of Congress could be construed to "invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance". Given the fact that the State of Texas does not consider the Pharmacy Agreement at issue to be a part of its regulation of the insurance industry, *there is no conflict* between federal antitrust enforcement and protection of the state's traditional role of regulating its insurance industry. A McCarran Act exemption is therefore inappropriate in this case. Indeed, it would be anomalous for the Court to find that the challenged actions herein are regulated by the State of Texas as part of its business of insurance when the Texas State Board of Insurance has made a contrary determination.

4. The only regulatory concern of the State of Texas is to make certain that Petitioner Blue Shield meets its obligations to insureds under the Prescription Drug Insurance Policy. Blue Shield's *sole obligation* under the Policy is to see that its subscribers receive covered prescription drugs and that such subscribers *"shall be required to pay no more* than the drug deductible for each of such covered drugs." (emphasis supplied). The price fixing and boycott activities of Petitioners under the Pharmacy Agreement are *not* obligations Blue Shield has to its subscribers, and they are therefore outside of the State's regulatory concern.

5. The Pharmacy Agreement is merely a mechanism chosen by Blue Shield to meet its obligations under the Prescription Drug Insurance Policy. If the Pharmacy Agreement was construed to be in the "business of insurance" and regulated by Texas law, then Blue Shield could fix prices in all other industries involved in meeting the obligations of the Prescription Drug Insurance Plan. Illogical as it may seem, this anticompetitive activity could extend to typewriter, printing and pencil companies. The result being the insurance industry's intrusion into major sectors of our economy with anticompetitive and onerous arrangements. This potential proliferation of anticompetitive agreements would have the further result of making the Sherman Act, and the policy of liberal enforcement behind it, play "second fiddle" to an exemption statute, the McCarran Act. This "tail-wagging-the-dog" result was not intended by the Congress when it passed the McCarran Act.

6. In sum, the price fixing and boycott activities of Petitioners are not regulated by the State as part of the business of insurance. The State of Texas agrees with this conclusion. State concern in this case solely relates to the enforcement of Blue Shield obligations to subscribers under the Prescription Drug Insurance Policy. If the challenged activities were somehow held to be obligations under the Prescription Drug Insurance Policy regulated by the State law and in the business of insurance, then the Sherman Act would be subverted by untold numbers of "McCarran Act" price fixing arrangements.

CONCLUSION

For the reasons set forth herein, the judgment of the Court of Appeals for the Fifth Circuit should be affirmed.

Respectfully submitted,

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APPENDIX "A"

OPINION

THE ATTORNEY GENERAL
OF TEXAS

Austin 4, Texas

WILL WILSON
ATTORNEY GENERAL

Mr. William A. Harrison
Commissioner of Insurance
International Life Building
Austin 14, Texas

This Opinion
Affirms Opinion
#0-4986-A

Opinion No. WW-1475

Re: Whether, under the facts stated, Prepaid Prescription Plan, Inc. would be engaging in the business of insurance in furnishing the prescription service required by its service agreements and pharmacy contracts, and related questions.

Dear Mr. Harrison:

You have asked our opinion as to whether or not the business proposed to be conducted by Prepaid Prescription Plan, Inc. is an insurance business. In this connection you point to Attorney General's Opinion No. O-4986-A dealing with a somewhat similar problem and ask whether or not it is still in effect and, if so, whether or not it is correct.

In your request you outline the facts to be considered as follows:

> "The Prepaid Prescription Plan, Inc., is a domestic corporation chartered August 4, 1959, under the Texas Business Corporation Act. The Purpose Clause of its Articles of Incorporation provides as follows:
>
> > " 'ARTICLE THREE: The purposes for which the corporation is organized are:
> >
> > To establish, maintain and operate a prepaid prescription plan or plans whereby prescriptions, either oral or written by duly licensed physicians, may be dispensed by duly licensed pharmacists to individuals, either singly or in groups, who become subscribers thereto:
> >
> > And in furtherance thereof to enter into contracts with duly licensed pharmacists who are authorized to dispense prescriptions in compliance with the laws of the state in which they do business, whereby such pharmacists agree to provide such prescription service to its subscribers.'
>
> "Membership for a subscriber and/or his dependents is available on a group plan or a pay direct plan upon making application for enrollment on an application form furnished by the company, payment of service fees, and upon acceptance of such application by the company

and the issuance of Service Agreement. Membership for a pharmacy in the plan may be obtained by submitting application on a form furnished by the company, payment of membership fee, and execution of Pharmacy Contract. Copies of both type applications and a copy of the Service Agreement and Pharmacy Contract are enclosed herewith for your information as to the exact terms of these instruments.

"The Prepaid Prescription Plan, Inc., is a stock company with the stockholders being the owners of the corporation and entitled to receive profits upon their investment in the stock.

"For and in the consideration of the payment of the monthly service fee provided for in the Service Agreement a subscriber, after obtaining a legal prescription from a licensed physician, may have the prescription filled by any Member Pharmacy and pay one-third or one-half of the prescription selling price according to the Service Agreement. Prescriptions may be obtained from other than a Member Pharmacy only under certain conditions as set out in the Service Agreement after securing approval of the pharmaceutical director of the company. The company pays directly to the Member Pharmacy the two-thirds or one-half the price of the

prescription, as the case may be, which is computed and based upon a schedule of prices as provided for in the Pharmacy Contract. The "prescription selling price" upon which the subscriber's one-third or one-half is computed may be different from the price upon which the company's two-third or one-half is computed.

"The Prepaid Prescription Plan, Inc., acts as an agent for the subscriber and for the member pharmacist but specifically assumes no liability for the performance of the Member Pharmacy."

Insurance has been defined in *Ware v. Heath*, 237 S. W. 2d 362, (Civ. App. 1951), as: "An undertaking by one party to protect the other party from loss arising from named risks, for the consideration and upon the terms and under the conditions recited" citing Couch's Cyclopedia of Insurance Law, Vol. I, page 2. As stated in National Auto Service Corporation v. State, 55 S. W. 2d 209, (Civ. App. 1932; error dism.): "Whether or not a contract is one of insurance is to be determined by its purpose, effect, contents, and import, and not necessarily by the terminology used, and even though it contain declarations to the contrary. . ." We have concluded that under the facts presented Prepaid Prescription Plan, Inc., hereinafter referred to as the corporation, will be conducting an insurance business.

Examining the contracts furnished us in connection with the opinion request, it can be seen that the benefit to the holder of the service agreement is the obtaining of prescription drugs at a reduced rate, the difference

between the amount paid by the subscriber to the pharmacy and the actual sale price being paid to the pharmacist by the corporation.[1] The risk insured against is the possibility that the subscriber's doctor, during the period covered by the service agreement, might see fit to prescribe drugs for his treatment; the filling of which prescriptions would entail an expenditure by the subscriber. In the event of serious illness to the subscriber, he conceivably could be financially unable to purchase the necessary drugs at the current market price. After entering into the service agreement in question, a portion of this risk is distributed to the corporation, for it has agreed (by virtue of the contract between it and the subscriber and between it and the member pharmacy) in consideration of the monthly payment of $1.50 or $1.60 (depending on whether or not a group or an individual is a contracting party) to reimburse a member pharmacy a portion of the price of each prescription filled by the pharmacy for the subscriber. The contingency upon which the payment rests is the filling by the pharmacy of a prescription written by a doctor and submitted to the pharmacy by a subscriber to the Plan. It will be noted that the pharmacy takes no risk. It is completely reimbursed, partly by the subscriber and partly by the corporation — in some respects analogous to deductible hospitalization policies. On the other hand the corporation, organized for profit, is gambling that its cost for prescriptions filled for its subscribers will be less than the amount taken in through the monthly payments.

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[1] As pointed out in your opinion request, the prescription selling price upon which the subscriber's payment is computed may be different from the price upon which the corporation's payment is computed. This, however, is not material to the question presented.

We can find no cases in this or other jurisdictions passing upon arrangements exactly the same as that herein involved. It resembles in some respects and is presumably based upon medical plans previously passed upon by the courts of certain other jurisdictions, primarily the group health or group medical plans which came into vogue during the depression. The earliest case in this general field is *State ex rel. Fishbach v. Universal Service Agency*, 151 Pac. 768, (Wash. Sup. 1915), which was an action by the insurance commissioner of the State of Washington to forfeit the charter of the Universal Service Agency for doing an insurance business without complying with the insurance regulations. The agency entered into contracts with a pharmacist, a doctor, a grocer, and a shoe dealer, the dealers contracting to sell their products at a fixed rate or a fixed discount and the doctor contracting to render medical services for a fixed consideration. The agency also entered into contracts with individuals for the fixed sum of $15.00 per year plus $5.00 for each child covered by the agreement. The products purchased from the dealers were paid for by the individuals purchasing same and the doctor's compensation was a fixed amount out of each membership fee and did not vary with the treatments rendered. The agency assumed no liability for breach of the contract by the doctor or the dealers. The court held that the agency was not in the insurance business because it was insuring against no peril. It can be seen that the arrangement is not the same as that passed upon in this opinion, for the agency obviously assumed no risk that the payments it was called upon to make would exceed the amount which it was taking in from the contract holders.

There are also in existence a group of opinions dealing with group medical plans which are epitomized by the opinions in *California Physicians' Service v. Garrison*, 172 P. 2d 4, (Cal. Supp. 1946), 167 ALR 306, and *Jordan v. Group Health Association*, 107 F.2d 239, U.S. Court of Appeals, (1939). In both, the formation of the particular type of corporation involved was authorized by statute, both were non-profit and both encompassed group service only. In the *Garrison* case the subscriber's dues amounted to $1.70 (male) and $2.00 (female) a month. The doctors contracted with the service to make available their medical services in return for a payment on a unit basis, i.e., a pro rata distribution *of the dues collected for that month*, depending upon the amount of service which they rendered. In the *Jordan* case, the doctors were paid a fixed annual compensation. In both cases the business was held not to be insurance in nature. As pointed out in the *Jordan* opinion, the corporation assumed no risk and acted only as an agent. If any risk was assumed it was assumed by the doctor. There was no possibility in either case that the cost to the service or group association for the services rendered by the doctors would exceed the amount taken in in monthly dues.

To the same effect is the case of *Commissioner of Banking and Insurance v. Community Health Service*, Court of Errors, New Jersey, 30 A. 2d 44 (1943). The stipulated facts in that case were to the effect that the defendant corporation contracted with doctors for one year periods for fixed consideration the amount of which varied with the number of individual contract holders but not with the amount of service rendered. The court held on the authority of the *Fishback* case that this was not an insurance business. Of interest to the

question before us is the fact that the state contended that the amount of compensation to be paid to the doctor depended upon and would vary with the amount of services rendered regardless of the amount of dues taken in. The court clearly pointed out that it had been stipulated that the compensation was fixed and that the amount of the service rendered would not affect in any way the compensation paid by the service to the doctor. The converse of that situation, of course, is the one with which we are dealing.

Even in the group health field, however, some jurisdictions have held these arrangements to constitute insurance. This is true in the case of *Cleveland Hospital Service Association v. Ebright*, Court of Appeals of Ohio, 45 N.E. 2d 157, affirmed by the Supreme Court of Ohio, 49 N.E. 2d 929 (1943), even though the particular type of corporation was specifically authorized by statute. In that case the amount to be paid to the hospital by the Service Association varied with the amount of service rendered. The opinion reads in part as follows:

> "The advantage to the subscriber, if he invokes the benefits of his contract, requires payment in money which is definitely measured by the extent of service rendered to the subscriber by the hospital to which he elects to go. It is payable upon a contingency, namely, that it is certified by his attending physician that the subscriber requires hospitalization . . . The contract, in probability, is not to indemnify the subscriber because the hospital which he selects does not extend credit to him and, therefore, there is no primary liability on his part which would be essential to make the service association an indemnifier. The amount which is

> paid by the subscriber is a charge based upon an actuarial determination of the probable risk incurred in issuing the contract, although that which is provided the subscriber upon the happening of a contingency is so far as he is concerned, service, yet it is measured by a money consideration payable to the hospital because of the rendering of that service to the subscriber on behalf of the plaintiff association."

The group of cases holding that group medical service contracts do not constitute insurance have been attacked insofar as the legal soundness of their reasoning is concerned by law review articles which are, however, favorable to the concept of group health service. For example, the writer in 53 Yale L.J. 162 in speaking of the Jordan case criticizes the failure of the court "to recognize the underlying risk — distribution function of prepayment — to insure the potential patient against the unpredictable occurrence of sickness." Likewise, in 52 Harvard Law Review 809 appears the following: "And while the distinction between contracts for services and contracts of insurance is sometimes shadowy, it seems clear, that in the case of cooperative health associations, indemnification against medical cost rather than the unique services of the physician is the principal object of the relationship."

These principles seem even more applicable to a corporation for profit of the type with which we are here concerned. We, therefore, conclude that the plan of operation intended to be followed by Prepaid Prescription Plan, Inc., would involve the doing of an insurance business in this state.

This opinion conflicts in no way with the holding in Opinion No. O-4986-A. The facts which were at that time before this office and which are revealed in the opinion itself, show that the health service was of the cooperative type, squarely within the holding of the Jordan case above cited. We, therefore, affirm the holding of that opinion.

Supreme Court, U.S.
FILED
JUL 13 1978
MICHAEL RODAK, JR., CLERK

In the Supreme Court

of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, et al.,

Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS, and DISCO PHARMACY, et al.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

AMICUS CURIAE BRIEF OF THE PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon nonprofit corporation

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AMICUS CURIAE BRIEF OF THE PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon nonprofit corporation

By consent of the parties the Portland Retail Druggists Association, Inc. files this brief as *amicus curiae* in support of Respondents.

INTEREST OF THE AMICUS CURIAE

The Portland Retail Druggists Association, Inc. ("PRDA") was the partially prevailing Respondent in *Abbott Laboratories* v. *Portland Retail Druggists Assn., Inc.*, 425 U.S. 1 (1976), which construed the 15 U.S.C. § 13c nonprofit institutions exemption to the Robinson-Patman Act, 15 U.S.C. §§ 13, et seq.

Abbott and the case at bar both involve drugs and the extent of exemption from the antitrust laws of activity in drugs.

This Court's decision in the case at bar will affect an antitrust case in which the PRDA is the plaintiff: *Portland Retail Druggists Association, Inc.* v. *Kaiser Foundation Health Plan, et al*, U.S.D.C. C.D. Cal., Civil No. 77-1458-IH.

On January 23, 1978, said complaint and a companion complaint were dismissed from the bench by the Honorable Irving Hill, U. S. District Judge, on the ground, among others, that defendants' drug purchases at preferential prices were exempt from the antitrust laws by the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 ("the Act").

The PRDA believes that the Fifth Circuit decision before this Court is a correct statement of the law and that cases and arguments relied upon by Petitioners and their *amici* are based on an erroneous construction of the Act.

The PRDA submits that if Petitioners prevail,

"nonprofit" and for-profit insurance companies and health care providers will have a license to boycott, coerce and intimidate, and to monopolize goods and services financed by insurance and health care premiums, to the injury of competition, subscribers and the general public.

QUESTIONS PRESENTED

1. Does the McCarran-Ferguson Act authorize a health care provider to compel its subscribers to purchase drugs exclusively from designated suppliers or forego the drug "benefit" paid for by the subscriber and/or his employer?

2. In the absence of a specific enabling state statute, does the McCarran-Ferguson Act authorize a health care provider to compel its subscribers to purchase drugs exclusively from designated suppliers or forego the drug "benefit" paid by the subscriber and/or his employer?

3. Does the business of insurance under the McCarran-Ferguson Act include the designation by a health care provider of the exclusive sources of drugs to be obtained by subscribers pursuant to the drug "benefit" provisions of their contracts?

4. Does the business of insurance include goods —in this case, drugs—financed pursuant to a health care contract?

SUMMARY OF ARGUMENT

Statutory exemptions to the antitrust laws are to be strictly construed against any claimed exemption, and this principle applies to the McCarran-Ferguson Act.

Good motives or intent are not a defense to violation of the antitrust laws.

No Texas statute or regulation authorizes a health care provider to discriminate against a non-discriminating pharmacy and a health care subscriber who exercises his freedom of choice to patronize a non-participating pharmacy.

In enacting the McCarran-Ferguson Act the Congress did not intend to include goods and services as part of the business of insurance.

Petitioners can contain the cost of drugs without violating the antitrust laws.

Statutory exemptions to the antitrust laws are to be strictly construed against any claimed exemption, and this principle applies to the McCarran-Ferguson Act.

The antitrust laws are to be construed liberally and exemptions from their application are to be construed strictly against the claimed exemption. *Abbott Laboratories* v. *Portland Retail Druggists Assn., Inc.*, 425 U.S. 1, 11 (1976).

Thus this Court ruled in favor of competition in *St. Paul Fire & Marine Insurance Co.* v. *Barry*, —

U.S. —, 38 CCH S. Ct. Bull. p. B4089, decided June 29, 1978.

Good motives or intent are not a defense to violation of the antitrust laws.

Much of the *amici* briefs siding with Petitioners harp on the good motives of Petitioners and claim that affirmance of the Court of Appeals will work a hardship on health care providers and their subscribers. Similar rationalizations favoring vitiation of the federal antitrust laws offered by Petitioners' *amici* were rejected by this Court in *St. Paul Fire & Marine Insurance Co.* v. *Barry, supra.*

It cannot be emphasized too strongly that the scheme struck down by the Court of Appeals foreclosed competition among providers of drugs. In theory the scheme allowed a subscriber to obtain a drug covered by the pharmacy benefit from the pharmacy of his or her choice, but the discrimination effectively discouraged obtaining of the drugs from any but a participating pharmacy.

Petitioners discriminate against a non-participating pharmacy and any subscriber who purchases drugs from a non-participating pharmacy, to the detriment of the subscriber's freedom of choice, to the partial denial of his pharmacy benefit, and the foreclosure of competition in the sale of drugs and drug-related services. *Royal Drug Co.* v. *Group Life & Health Ins. Co.*, 556 F2d 1375, 1379 (5th Cir. 1977) details the discrimination.

Assuming *arguendo* some "savings" to subscribers were reflected in lower premiums (and the record appears silent on this point) good intentions, "savings" and similar rationalizations are not a defense to violation of the antitrust laws.

United States v. *Topco Associates, Inc.*, 405 U.S. 596, 610 (1972) held:

> "Antitrust laws in general and the Sherman Act in particular, are the Magna Carta of free enterprise. They are as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms.
>
> (no paragraph)
>
> And the freedom guaranteed each and every business, no matter how small, is the freedom to compete—to assert with vigor, imagination, devotion, and ingenuity whatever economic muscle it can muster.
>
> (no paragraph)
>
> Implicit in such freedom is the notion that it cannot be foreclosed with respect to one sector of the economy because certain private citizens or groups believe that such foreclosure might promote greater competition in a more important sector of the economy. . . ."

Also see *Albrecht* v. *Herald Company*, 390 U.S. 145, 154 (1964). In the case at bar the Petitioners seek judicial approval of the foreclosure of competition for the alleged benefit of subscribers.

If Petitioners prevail the major beneficiaries will be the stockholders of the for-profit insurance companies and the "captive" and other designated suppliers of insurance premium-financed goods and services.

No Texas statute or regulation authorizes a health care provider to discriminate against a non-participating pharmacy and a health care subscriber who exercises his freedom of choice to patronize a non-participating pharmacy.

Implicit in the insurance codes of the various states is the doctrine of protecting the insurer against loss and discrimination, *e.g.:*

> "The Legislative Assembly declares that the Insurance Code is for the protection of the insurance-buying public." (§ 731.008, Oregon Revised Statutes).

Petitioners and their *amici* do not cite the Texas definition of the business of insurance in *Tex. Ins. Code Ann.* Art. 1.14-1, § 2 (Supp. 1977).

The comprehensive statute does not identify goods and services as part of the business of insurance.

The statutory omission is evidence of legislative intent to exclude goods and services from regulation as insurance.

In enacting the McCarran-Ferguson Act the Congress did not intend to include goods and services as part of the business of insurance.

The McCarran-Ferguson Act was passed in reaction to this Court's decision in *United States* v. *South-Eastern Underwriters Assn.*, 322 U.S. 533 (1944) to give support to the then existing and future state systems for regulating and taxing the business of insurance. *St. Paul Fire & Marine Ins. Co.* v. *Barry, supra,* at B4097-98.

Petitioners and their *amici* do not cite any legislative history to support their claim that the Act includes goods and services.

Petitioners apparently concede that provision for drugs was not within the contemplation of Congress during the deliberations leading to the Act:

> "The insurance program here in issue had its origins in 1967 . . . ." (Br. for Pet. 6).

Applicable to the case at bar is this Court's ruling in *Abbott Laboratories* v. *Portland Retail Druggists Assn., Inc., supra,* at 425 U.S. 1, 13:

> ". . . there is nothing in the Act that indicates that its exemption provision is to be applied and expanded automatically to whatever new venture the nonprofit hospital finds attractive in these changing days. The Congress surely did not intend to give the hospital a blank check. Had it so intended, it would not have qualified purchases by nonprofit institutions in the way it did in § 13c. . . . ."

Similarly, Congress did not give insurance companies "a blank check" to violate the antitrust laws

with impunity. The legislative record is to the contrary.

To paraphrase *Abbott Laboratories* v. *Portland Retail Druggists Assn., Inc., supra,* at 425 U.S. 14:

> We therefore conclude that the exemption of the Act as a limited one; that just because it is an insurance company does not mean that all its activities are exempt from the antitrust laws; that the test is the obvious one inherent in the language of the statute, namely the "business of insurance;" and an insurance company's discriminatory provisions for goods and services are not the "business of insurance" under the Act.

The essence of insurance is the underwriting of risks in exchange for a payment by the insured and money payment to the insured for insured losses.

This Court held that a merger of insurance companies approved by the Arizona Insurance Commissioner was not exempt from Securities and Exchange Commission action under the Act: *Securities and Exchange Commisison* v. *National Securities, Inc.*, 393 U.S. 397 (1969).

Other alleged insurance company activities similarly have been held outside the Act:

Zelson v. *Phoenix Mutual Life Insurance Company*, 549 F.2d 62 (8th Cir. 1977)

Battle v. *Liberty National Life Insurance Company*, 493 F.2d 30 (5th Cir. 1974)

Ray v. *United Family Life Insurance Company, Inc.*, 430 F. Supp. 1353 (N.C. 1977)

American Family Life Assurance Company of Columbus v. *Planned Marketing Associates, Inc.*, 389 F. Supp. 1141 (Va. 1974)

Hill v. *National Auto Glass Co.*, 293 F. Supp. 295 (N.D. Cal. 1968)

Continental American Life Insurance Company v. *City of Wilmington*, 273 A.2d 277 (Del. Super. 1970)

Petitioners can contain the cost of drugs without violating the antitrust laws.

Petitioners and various of their *amici* argue that containment of costs is part of the business of insurance exempt under the Act, but cite no relevant statute or legislative history of the Act.

Control of or reduction of costs of insurance has never been deemed an excuse to violate the antitrust laws.

Petitioners have available traditional and other legal methods of reducing their financial exposure to the cost of drugs provided pursuant to a drug benefit, *e.g.*, a limit on the drugs covered by the benefit, a dollar maximum on the amount of drugs purchased.

CONCLUSION

The Court of Appeals should be affirmed.

Respectfully submitted,

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Supreme Court, U. S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY,
Also known as BLUE SHIELD OF TEXAS, et al.,
Defendants-Appellants

vs.

ROYAL DRUG COMPANY, INC., doing business as
ROYAL PHARMACY OF CASTLE HILLS
and DISCO PRESCRIPTION PHARMACY, et al.,
Plaintiff-Appellees

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

AMICUS CURIAE BRIEF OF AUTOMOTIVE SERVICE COUNCILS, INC.

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On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

AMICUS CURIAE BRIEF OF AUTOMOTIVE SERVICE COUNCILS, INC.*

Automobile Service Councils, Inc. (ASC) is incorporated in the State of Illinois as a nonprofit and tax exempt corporate body. As a national trade association it represents over 5,000 independent businesses in the automotive repair and service industry. It is organized as a federation of regional, state and local trade associations usually incorporated by members who are individuals, partnerships or small corpora-

* Consent required for filing of this Amicus Curiae Brief by Rule 42(2) has been granted by the parties in a joint letter dated April 10, 1978 and filed with the Court on April 13, 1978.

tions servicing and repairing motor vehicles. These comparatively small businesses have the tools, equipment, skilled manpower and facilities necessary to perform competent motor vehicle repair, maintenance and related services for their customers. They compete on a daily basis with many larger, well financed corporate chain and new car dealer franchises.

THE INTEREST OF THE AMICUS CURIAE

ASC members are small enterprises engaged in the business of automobile service and repair. A large dollar amount of their revenues is earned from repairing automobiles which have been damaged in collisions. This collision repair work is not only the largest source of business for many members, but some are exclusively "body shops". This work usually involves the automobile insurance companies because their insureds, the automobile owners, are the customers and potential customers for which ASC members compete. For this reason the survival of many ASC members depends to a large extent upon the practices of insurance companies and their adjusters. Many of the practices engaged in by the insurance companies are of an anticompetitive nature, but for which insurance carriers have eluded antitrust liability asserting an alleged exemption of such practices from the application of the antitrust laws because of the McCarran-Ferguson Act.

Annually there are approximately 23 million auto collision related repairs for which insurance companies pay claims. These claims payments are estimated to be in excess of ten billion dollars annually.

ASC, acting for its members and other members of the auto repair industry, has a vital interest in this matter. ASC members identify with the plaintiff

pharmacies because they perceive the Pharmacy Agreements, as characterized by the Court of Appeals, to be "price fixing agreements". In much the same way the automobile repair industry has been subjected to fixed prices or rates of repair, by insurance companies' agreements.

The "Participating Pharmacy Agreement" not only restrains competition among pharmacies, but also excludes the nonparticipant from any effective access to the insureds' drug needs. A requisite parallel exists with insurance company practices applicable to automobile repairers. Those repairers who refuse to accept uniform practices and prices of the insurance carriers are excluded from not only present, but also future business with any such insurer. It is common practice for large insurance companies to engage in boycotts, coercion and intimidation to achieve discounts on parts, labor and other materials to be furnished by the auto repair shops. They designate acceptable repair shops on a "preferred list". As the member of the health maintenance plan should be free to choose to deal with a nonparticipant pharmacy, an insured auto owner should be free to choose any auto repairer. Free competition in the open market place should be the determinent factor in prices and costs.

ASC, on behalf of its members and all others in the auto repair industry, files this Amicus brief because the insurance company's practices encountered by the plaintiff pharmacies are similarly encountered by the auto repair industry. The net result to both is to restrain trade, unduely restrict competition and to cause serious economic injury to the public. These contractual arrangements are not the "business of insurance"

but rather a blatant violation of the Federal Antitrust Laws.

The central issue is whether the "Pharmacy Agreements" which are admittedly restraints of trade and which result in an intended boycott of these plaintiffs fall within the perview of the McCarran-Ferguson Act exemption. However the impact of the resolution of this issue involves far more than the Pharmacy Agreements. The resolution of the question will either be the beginning point of other contractual arrangements which insurance companies will institute and expand under the red herring of "cost containment" or it will be the end of such anti-competitive conspiracies and agreements. The case has other important considerations than price fixing agreements among drug stores and health insurance companies. It goes to the relationship of all third parties who may wish to compete in a free and open market place to provide services or products to consumers.

SUMMARY OF ARGUMENT

The decision of the Court of Appeals for the Fifth Circuit is eminently correct that such contracts must be judged under the full light of the antitrust laws. This Amicus respectfully submits that the Court of Appeals properly found that by using the test supplied by this Court in *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 US 453 (1969) and in *St. Paul Fire & Marine Insurance Co., et al* v. *Barry et al*, No. 77-240 decided June 29, 1978; 555 F. 2d 3 (CA 1 1977), that such contracts as exemplified by the Pharmacy Agreements are not immune to antitrust scrutiny.

The Circuit Court recognized, as this Court does, that the central point in this matter involves two competing

ideas or rule systems. The antitrust laws have been enacted to prevent unreasonable trade restraints and the destruction of competition. Therefore any exemption to the antitrust laws must be strictly construed.

As to the insurance industry, Congress enacted the McCarran-Ferguson Act so as to limitedly authorize carriers to take actions which otherwise might violate the antitrust laws. The extent of this exception must, obviously, be given the closest scrutiny.[1] The Circuit Court was correct in refusing to expand the exemption to cover the Pharmacy Agreements.

There no longer exists any question that only an extremely limited number of business practices of insurance companies are within the McCarran-Ferguson exemption. The Pharmacy Agreements are not an essential part of the "business of insurance". Blue Shield could write the insurance coverage for drugs and pharmaceuticals without the Pharmacy Agreements, and in fact, that is what transpires when an insured has a prescription filled by a nonparticipant. The insurer owes no obligation to its insureds to fix retail

---

[1] This is particularly true when the courts are called upon to resolve a conflict in statutes presuming that Congress intended to "implicitly repeal" a certain provision of the antitrust laws to an extent that it would authorize the conduct which, otherwise would violate the antitrust laws. An "implied exemption" is similar to an "implied expansion of an exemption" and these are not easily deduced:

> it is cardinal principle of construction that repeals by implication are not favored, when there are two acts on the same subject and the rule is to give effect to both if possible . . . There must be a positive repugnancy between the provisions of the new law, and those of the old; and even then the old law is repealed by implication only *pro tanto* to the extent of the repugnancy." *United States* v. *Borden*, 308 US 188, 198 (1939).

prices. Such conduct is repugnant to our well established public policy of free and open competition. The reliability of Blue Shield need not depend upon its ability to determine retail prices, fix them by agreement with certain suppliers, and then administer its program of claims and payments in a way to exclude nonparticipating suppliers and to coerce them to participate.

ARGUMENT

I. THE CIRCUIT COURT OF APPEALS CORRECTLY DETERMINED THAT THE PHARMACY AGREEMENT IS NOT A PART OF THE BUSINESS OF INSURANCE AND IT IS NOT COVERED BY THE EXEMPTION OF THE McCARRAN-FERGUSON ACT.

While the history of the Blue Shield Health Care Agreements is interesting, particularly that it is the result of union negotiated contracts, it has little significance in this matter. While it is also true that defendant Blue Shield is regulated by the Texas Board of Insurance, that too has little to do with the Pharmacy Agreements.

Two points can be made concerning the Pharmacy Agreements. The first is that no matter how much discussion or analysis of the purpose of health care organizations and their methods of contracting and operating, it will not extend them special privileges nor expand the McCarran-Ferguson Act. The alleged benefits they provide and the alleged good services performed do not relieve them from antitrust standards. The second point is that the review and approval of the State Board of Insurance of Texas does not change the character nor the use, and the resulting injury caused by the use of the Pharmacy Agreements.

The petitioners argue that regulation of the Blue Shield's policies and Pharmacy Agreements under the Texas Insurance Code confirms that they are the "business of insurance". (Petitioner's Brief, Page 31) They refer to "pervasive" regulation by the State Board of Insurance and the conclusion of the Attorney General of Texas as demonstrative that the agreements are the "business of insurance". The approval of the State Board described by the Circuit Court is not "pervasive" regulation and it does not prove that these Pharmacy Agreements were anything other than what that court found them to be.

Similarly a contract and riders used by automobile insurers, are submitted for state board or commission approval. The rates charged are submitted for state approval, and other systems of operations are subject to state scrutiny including claims processing and settling procedures, but none of these functions should be allowed to ruin competition or to fix the prices for automobile repair. Not every insurance company function a state insurance commissioner or state attorney general may review is business of insurance and the review does not make it so, and bring that within the McCarran-Ferguson Act in order to remove it from Federal Antitrust. *St. Paul Fire & Marine Insurance Co., et al.* v. *Barry, et al,* No. 77-240, decided June 29, 1978; 555 F. 2d 3 (CA 1 1977).

The Circuit Court considered the petitioner's arguments concerning state regulation and whether this made it business of insurance. The Court said:

> It is clear from the record that the Board has never approved the Pharmacy Agreement and the Division Manager of the Board's Policy Approval Division, a Mr. Pogue, testified that he thought

> the Pharmacy Agreement was outside the state's regulatory control . . .
>
> The testimony of these officials, therefore, at best raises a factual issue concerning the state's position. (Referring to testimony of Mr. Pogue and a former State Board employee, Mr. Connor.) (556 F.2d 1375, 1384-85)

The Pharmacy Agreement did not come under the jurisdiction of the State Board of Insurance for the simple reason that it did not constitute the "business of insurance."

In summary, the Pharmacy Agreements were not the "business of insurance" by their very nature and purpose. They could not be made so by the alleged good purpose claimed by the petitioners.

II. THE McCARRAN-FERGUSON ACT EXEMPTION SHOULD BE STRICTLY CONSTRUED AND THE TERM BUSINESS OF INSURANCE APPLIED AS A LIMIITED AND NOT EXPANDABLE TEST.

The *National Securities* definition of the term "business of insurance" was properly applied by the Circuit Court. The relationship between insurer and insured is not dependent upon these Pharmacy Agreements. The petitioners argue that the Pharmacy Agreement determines the type of insurance policy issued and thus it is the "business of insurance". (Petioner Brief, Page 14) This is not a logical conclusion. The basic consideration is that Blue Shield in no way needs the Pharmacy Agreement as a part of its insurance program. This is made obvious by the provisions of its program for nonparticipating pharmacies. The Circuit Court analyzed the contract of insurance and made the legal obligation plain:

> Blue Shield's sole obligation is to see that the insured received prescription drugs and shall be required to pay no more than the drug deductable for each of the covered drugs. It is unnecessary for Blue Shield to agree with pharmacies to fix retail prices in the pharmaceutical industry." (556 F.2d 1375, 1381)

The plaintiffs reason that Blue Shield could have offered a different contract, but in the exercise of its business judgment it "decided to issue policies providing for goods and services benefits rather than offering cash indemnification exclusively." This leads to thoughts of total health care maintenance systems or programs. These systems require contracts with various suppliers, hospitals and physicians. The reasoning then turns to "low cost delivery" or "cost containment". There is no doubt that these are important objectives but not at the expense of independent competing businesses. Furthermore, while lip service is paid to this concept, that is all that is done. Fair, free and open competition, by its very nature has been found on numerous occasions by this court to be the best method of "cost containment".

The Circuit Court recognized that the McCarran-Ferguson Act, by its nature and purpose, must be narrowly construed and not given an expanded construction. It recited the illustrations used by the appellees that "automobile insurers will be able to utilize participating Repair Shop Agreements and coercion to fix prices for parts and labor in the automobile industry." It described possible agreements among fire insurance companies and construction companies. The court properly rejected the temptation to think expansively.

The danger, of course, of such expansionary thoughts is always present when large financial institutions extend influence and control by means of agreements which determine costs, margins, amounts of services and the prices of goods and services which are to be supplied by a very narrow group of selected suppliers.

The domination of the auto repair shops by the insurance carriers often forces the shops to employ a lower quality of repair to the insured's vehicle thus inflicting accelerated depreciation in the value of the insured's vehicle. We estimate this hidden loss to be approximately $500 million annually.

III. THE PRESENCE OF PRICE FIXING SUPPORTED BY COERCION AND BOYCOTT DIRECTED AGAINST SMALL COMPETITORS PRECLUDES JUDICIALLY EXTENDING THE McCARRAN-FERGUSON ACT EXEMPTION TO INCLUDE ALL PROVIDER AND SERVICER ARRANGEMENTS.

Most of the arguments supporting the position of the insurance company rely heavily on the proposition that anything that helps to reduce or contain the cost of insurance must benefit the public to such an extent that Congress must have intended to legislate assistance to this good purpose. However, in this matter, the nonparticipating pharmacies should not be sacrificed to promote this result and it is submitted that Congress never intended such a result.

Few would disagree that the setting of insurance premium rates to be charged to the insurance customer by the insurance company is the business of insurance under the McCarran-Ferguson Act and *National Securities*. It appears from some cases, however, that the insurance companies are trying to succeed in mixing the labor rates and product costs of third party suppliers with state regulated premium rates. This was rejected by the Fifth Circuit as unnecessary and unwarranted.

The Fifth Circuit Court was not persuaded to follow *Manasen* v. *California Dental Services,* 424 F. Supp. 657 (N.D. Cal. 1976); *Anderson* v. *Medical Service of the District of Columbia,* 551 F. 2d 304 (4th Cir. 1977) and *Frankford Hospital* v. *Blue Cross,* 554 F. 2d 1253 (3d Cir. 1977), and it distinguished *Travelers Insurance Company* v. *Blue Cross,* 481 F.2d 80 (3rd Cir.), cert. denied, 414 U.S. 1093 (1973). Whether there is any distinction in principle between these cases and *Royal* is arguable. It is obvious that it is easier to find the health services agreements with hospitals and physicians to be included within "business of insurance". As the court said "the *Travelers* decision was based in large measure on the Pennsylvania legislature's control over rates charged by nonprofit hospitals." In *Anderson* the matter involved a suburban physician with a substantial practice and the defendant insured medical-surgical benefits to some 1,300,000 persons in metropolitan Washington, D.C. Some 93% of the practicing doctors in the area were participating physicians under contract and plaintiff was the only nonparticipant in Northern Virginia. These cases differ markedly on the facts from *Royal.*

The Circuit Court summed up the matter well in dismissing the importance of one of these contrary decisions:

> *Manasen* and other cases have emphasized the favorable impact that price fixing and coercion have had on insurance premiums and the 'reliability' of the insurers. It is conceivable that the public might benefit from price fixing arrange-

ments as long as parties to the arrangements agree to keep prices below free market levels. The Congress, however, has foreseen that the power to fix prices might not always be beneficially administered by those parties holding the power once their competition has been put out of business." (556 F. 2d, 1387, 1386)

A very recent decision of this court in *St. Paul Fire & Marine Insurance Co. et al.* v. *Barry et al.*, No. 77-240, decided June 29, 1978; 555 F. 2d 3 (CA 1 1977), did not involve Section 2(b) of the McCarran-Ferguson Act, but the examination and application of the legislative history of McCarran-Ferguson applies. *Barry* involved Section 3(b) and the interpretation of the term "boycott".[2] The Court commented that:

> The debates make clear that the 'boycott' exception was viewed by the Act's proponents as an important safeguard against the danger that insurance companies might take advantage of purely permissive state legislation to establish monopolies and enter into restrictive agreements falling outside the realm of state-supervised cooperative action." (Slip Op. P 14-15)

The broad and unqualified language of Section 3(b) was not intended to limit its application to insurance companies or agents and was not intended to preclude Sherman Act protection for policyholders and others.

---

[2] As the Court describes it:

> Section 2(b) is not in issue in this case. Rather we are called upon to interpret, for the first time, the scope of Sec. 3(b), the principal exception to this scheme of pre-emptive state regulation of the "business of insurance".
>
> The Court of Appeals in this case determined that the word "boycott" in Sec. 3(b) should be given its ordinary Sherman Act meaning as "a concerted refusal to deal". (slip op. p. 7-9)

Petitioners in *Barry* wanted the Act interpreted favorably to them by the narrowest construction of Section 3(b). They reasoned incorrectly that since the Court broadly interpreted Section 2(b) of the Act in *National Securities* and in *FTC* v. *National Casualty Co.*, 357 U.S. 560 (1958), that Section 3(b) must be narrowly construed to further the broad purpose of Section 2(b). The Court rejected this reasoning:

> . . . Section 3(b) is an exception to Section 2(b), and (that) Congress intended in the "boycott" clause to carve out of the overall framework of plenary state regulation an area that would remain subject to Sherman Act scrutiny." (Slip Op. P. 19).

It has been shown, earlier in this argument that as the Court found in *Barry* "there was no state authorization of the conduct in question" in *Royal.*

It is reasonable to conclude that as Congress intended the practice of "boycott", which caused injury to policyholders of insurance companies, to be removed from the exemption of the Act, it also intended that the equally destructive practice of price fixing by agreement with third party suppliers which causes injury to nonparticipant parties, to be not exempted. There is reason to assume that some of these smaller competitor pharmacies would be eliminated by this Participating Pharmacy Agreement if the Circuit Court is not upheld. To reverse the Circuit Court would place an inordinate power over commerce into the hands of the insurance companies. Actual or potential abuse of such power calls for a strict interpretation of the exemption granted in the McCarran-Ferguson Act.

CONCLUSION

The Pharmacy Agreement is not within the "business of insurance". No other facts support any other conclusion. If the Fifth Circuit is not upheld a multi-billion dollar segment of the auto body repair industry will be without the protection of the antitrust laws. The Fifth Circuit should be affirmed.

Respectfully submitted,

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Respondents

On Writ of Certiorari to the United States
Court of Appeals for the Fifth Circuit

**AMICUS CURIAE BRIEF OF
THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS**

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE
AND HEALTH INSURANCE COMPANY,
also known as BLUE SHIELD OF TEXAS, et al.,

Petitioners

vs.

ROYAL DRUG COMPANY, INC., doing business as
ROYAL PHARMACY OF CASTLE HILLS
and DISCO PRESCRIPTION PHARMACY, et al.,

Respondents

On Writ of Certiorari to the United States
Court of Appeals for the Fifth Circuit

AMICUS CURIAE BRIEF OF
THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

All parties have consented to the filing of this Brief for *amicus curiae* in support of respondents, pursuant to Rule 42(2) of the Court.[1]

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[1] See letter to Mr. Rodak from counsel for Petitioners and Respondents (April 10, 1978).

INTEREST OF AMICUS CURIAE

The National Association of Retail Druggists (NARD) is a private, nonprofit, voluntary organization founded in 1898 and composed of independent retail pharmacists. NARD membership consists of over 20,000 independent pharmacists. Independent pharmacists fill over two-thirds of the prescriptions filled in the United States annually. Almost all NARD members participate in one or more third party prepaid prescription plans established by profit and nonprofit insurance companies,[2] by state Medicaid programs or by individual companies or unions.

Since their introduction in the early 1960's, third party plans have grown from representing less than 10% of all prescriptions filled by retail pharmacies to more than 24% in 1977.[3] This percentage is expected to continue to increase and, according to a recent NARD survey, already approaches 75 to 80% in some stores in certain parts of the country. As a result, the operation of these plans is of vital interest to retail pharmacists. Accordingly, the Fifth Circuit's decision that activities engaged in by insurance companies and pharmacists which set the price at which retail prescriptions are sold are properly subjects of review under the antitrust laws has a direct and significant impact on NARD members.

SUMMARY OF ARGUMENT

The antitrust laws have long been deemed by this Court to be among the fundamental laws of the land. This Court recently stated in *City of Lafayette*:

> [a]ntitrust laws in general, and the Sherman Act

[2] In addition to plans sold by Blue Cross/Blue Shield, insurance companies offering such plans include, among others, Aetna Life and Casualty Company, Allstate, John Hancock Mutual Life Insurance Company, Lincoln National Life Insurance Company, and Metropolitan Life Insurance Company.

[3] *American Druggists*, Annual Prescription Department Survey, May, 1978, p. 10.

> in particular, are the Magna Carta of free enterprise. They are as important to the preservation of economic freedom and our free enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms.[4]

The issue before this Court is whether the activities of Petitioners which set the price at which pharmacists sell prescription drugs to policyholders of Group Life and Health Insurance Company are within the "business of insurance" under the McCarran-Ferguson Act and should accordingly enjoy the limited exemption from the antitrust laws provided by that Act.[5] NARD believes that the legislative history of the Act, the policy underlying its passage, as well as this Court's longstanding admonition that antitrust exemptions be narrowly construed fully supports the Fifth Circuit's determination that efforts of insurance companies in combination with non-insurance providers to fix the price of goods or services sold to policyholders of the insurer do not constitute the business of insurance and are,

[4] City of Lafayette v. Louisiana Power and Light Co., — U.S. —, 55 L.Ed.2d 364, 374 n. 16, (March 29, 1978), citing U.S. v. Topco Associates, 405 U.S. 596, 610 (1972).

[5] McCarran-Ferguson Act §§1-3, 15 U.S.C. §§1011-1013 (1976) (hereinafter the "McCarran Act" or the "Act"). As Section I.B., *infra*, shows the effect of the McCarran Act is to allow the states to a limited extent to preempt federal law despite the fact that the activity involves interstate commerce. While this might more properly be termed a limited right of preemption, the McCarran Act has traditionally been discussed as one of the limited exemptions from the antitrust laws. This brief, therefore, uses the traditional term, "exemption."

In reviewing the briefs of the Petitioners and the Amici supporting Petitioners, it would appear that the issues in this case involve: the type of contract which an insurance company can offer an insured; the ways in which companies can supply benefits to employees; a national cost containment policy; and, the right of the states to regulate the business of insurance. *None of these matters are at issue in this case.* The attempt to engraft these issues on to the question of the scope of the exemption from the antitrust laws provided by the McCarrarn Act shows the bankruptcy of Petitioners' position.

therefore, properly subject to review under the antitrust laws. Accordingly, this Court should affirm that result.

The McCarran Act was enacted in response to this Court's holding in *South-Eastern Underwriters* [6] that insurance was commerce, and therefore subject to federal regulation and taxation. Until *South-Eastern Underwriters* the regulation and taxation of the business of insurance was the exclusive domain of states. Congress first considered and rejected legislation which would have totally exempted the business of insurance from federal antitrust laws. Instead Congress, after careful consideration, chose in the form of the McCarran Act to accommodate in conformity with our system of federalism two competing, and sometimes conflicting, legislative schemes. Thus section 2(b) of the McCarran Act provides that the federal antitrust laws are applicable to the business of insurance, except to the extent such laws conflict with state regulation of the business of insurance. Notwithstanding that general accommodation of state insurance regulation and federal antitrust law, Congress further balanced these interests by providing that with respect to agreements and acts of boycott, coercion or intimidation federal antitrust law must prevail over state insurance regulation.

Petitioners would do violence to this careful balance of state and federal regulation by urging this Court to accept a meaning of the "business of insurance" which is contrary to the clear Congressional understanding of the activities which constituted the business of insurance. Congress understood the business of insurance to consist solely of activities between and among insurance companies, their insureds, employees and agents.

Nothing in the legislative history of the Act remotely suggests that Congress intended to exempt from federal

[6] United States v. South-Eastern Underwriters Association, 322 U.S. 533 (1944) (hereinafter "South-Eastern Underwriters").

antitrust scrutiny activities engaged in by insurance companies which set the price for the sale of goods or services in non-insurance sectors of the economy. Nothing in the policy underlying the McCarran Act requires that the "business of insurance" be interpreted in a way which removes large segments of the non-insurance parts of the economy from the scope of the antitrust laws. Yet, by removing from review under the antitrust laws the legality of activities which set the price at which prescription drugs are sold, the position taken by Petitioners has that inevitable result.

This Court has had numerous occasions in recent years to examine a variety of exemptions to the antitrust laws. This Court has consistently held that such exemptions are to be narrowly construed. Petitioners ("Group Life"), however, seek to have this Court interpret one of the limited statutory exemptions from the antitrust laws in a way which is not necessary for the purpose of that exemption, was not contemplated by Congress, and which greatly expands its scope to the point that large segments of the economy fall under that exemption rather than under the more fundamental laws, the antitrust laws.

ARGUMENT

I.

THE FIFTH CIRCUIT WAS CORRECT IN FINDING THAT ACTIVITIES ENGAGED IN BY INSURANCE COMPANIES AND PARTICIPATING PHARMACISTS WHICH SET THE PRICE OF RETAIL DRUGS ARE NOT THE BUSINESS OF INSURANCE

The Fifth Circuit found that the combination entered into between Group Life and participating pharmacists in Texas which set the price for drugs at $2 for all participating pharmacists did not constitute the "business of insurance"

within the meaning of the McCarran Act.[7] The Fifth Circuit found that Group Life and Health Insurance Company was not required by its obligation to its customers or by state mandate to fix the retail price of prescription drugs.

Public and private third party prepaid prescription plans presently cover more than 24% of all prescriptions filled. In 1977, this 24% represented nearly 400 thousand prescriptions, which were sold for approximately 1.8 billion dollars.[8] The position taken by Group Life would exempt activities engaged in by insurance companies and participating pharmacists which would determine the price at which these drugs would be sold. In some areas third party prescriptions amount to 75 to 80% of all prescriptions filled. Because of the discriminatory payment provisions for non-participating pharmacists, a pharmacist unwilling to enter into a third party provider agreement with an insurance company is effectively excluded from the right to compete for that business within his community.

While it seems clear that these plans have the purpose and effect of fixing the retail price of these drugs, that issue is not before this Court. If the Court affirms the Fifth Circuit's decision, this case will return to the trial court for a determination of whether the arrangements between participating pharmacists and Group Life constitutes either an illegal price fixing arrangement or an illegal boycott of nonparticipating pharmacists. The only issue decided by the Fifth Circuit was that the activities engaged in by the insurance company and the participating pharmacists establishing the price at which the pharmacists would sell drugs to policy holders of the insurance company was not the business of insurance and, therefore, could be reviewed

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[7] Royal Drug Company, Inc. v. Group Life & Health Insurance Company, 556 F.2d 1375, 1383-7 (5th Cir. 1977).

[8] *American Druggists*, Annual Prescription Department Survey, May, 1978, p. 17.

under the antitrust laws. That decision is correct based on the history of the McCarran Act, the scope of the exemption provided by that Act and the proper relationship between that exemption and the antitrust laws.

A. Non-State Mandated Activities Engaged In By Insurance Companies Which Set The Price For Non-Insurance Products Are Not The Business Of Insurance.

As indicated above, the McCarran Act exemption is limited to the "business of insurance." To understand whether the activities at issue in this case fall within this term, it is necessary to review the specific activities involved in light of the legislative history, policy, and purpose of the McCarran Act.

Third party prepaid prescription plans generally are developed by insurance companies either independently or in conjunction with a plan sponsor, such as a union or corporation. Under these plans the insurance company insures against the risk that the insured will be unable to pay for prescription drugs during the period of coverage. The amount of the risk borne by the insured is negotiated between the insured and the insurance company. The amount of risk assumed by the insurance company can be lessened by requiring more co-payment by the insured or having an increased deductible. The insured and the insurance company may negotiate any form of policy they desire. If the policy, which governs the relationship between the insured and the insurance company, is regulated by the state, it is clear that it is exempted from antitrust review by the McCarran Act. This case, as the Fifth Circuit made clear, does not involve the question of the right of an insurance company to issue any type of policy to its insured on which the parties agree.[9] This is clearly part of the business of insurance.

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[9] Royal Drug, *supra*, 556 F.2d at 1382.

The rate the insured pays is determined by the insurance company based on its judgment of the cost involved in covering the risk it assumes. It is clear that states can regulate insurance company rates under the McCarran Act and that insurance companies can engage in certain cooperative activities in that regard. It is also clear that the establishment of a rate is part of the business of insurance.

Under traditional concepts of insurance, having set the rate, the insurance company either profits from such a policy or suffers losses depending on its skill in having predicted the scope of the risk it has assumed. In connection with third party plans, such as the one at issue, however, insurance companies have sought to ensure the profitability of such plans by controlling the price of the products and services covered by the policy. The insurance company accomplishes this by entering into agreements initially with those pharmacies prepared to accept a low fee either because of the minimal services offered by the pharmacy, or, because of their willingness to sustain a loss in their prescription departments because of their high profit margin in the many lines of non-pharmaceuticals sold. This agreement between high volume pharmacies, almost always non-pharmacist owned chain drug stores, is then "offered" to other competing pharmacists who either must accept the contract and the retail price established by it, or write off the business of the insured. All pharmacists accepting the contract are aware that all other pharmacists accepting the contract will be selling drugs to policyholders of the insurer at the same price. All pharmacists "offered" this contract are also aware that if they do not accept it they cannot compete for that portion of the business.

The effect of this combination between the insurance company and the chains is to lessen the consumer's choice concerning the types of pharmacy services available to him. Absent the artificial restraints imposed by the prices

established by this combination, one of the primary methods of competition between pharmacies is the provision of different types and levels of services, such as, direct consultation on drug use and interactions, patient profiles to assist in preventing improper drug interactions, delivery service for prescription drugs, as well as 24-hour emergency service. At the prices imposed by the combination of the insurance companies and the chains, the independent pharmacist is forced to offer the same limited services as the chains. As a result, the consumer is deprived of the opportunity of choosing between a full service pharmacy and the limited services available from most chains.

Except for the fact that the insurance companies desire to ensure their own profitability, there is no reason that third party provider contracts need to be established, or, if established, need to set the price paid by the insured. This is not only clear as a matter of common sense, but is amply demonstrated by the fact that a number of third party prepaid prescription plans utilize non-fixed fee payment methods and the fixed fee method is not used in most other forms of insurance.[10] While insurance companies may understandably desire to ensure their profitability, actions taken for that purpose are not necessarily "the business of insurance." As discussed in Section I.B. it is clear that nothing in the history, policy, or purpose of the McCarran Act, or in the cases decided by this Court interpreting the Act, support the view that activities which set the price of goods sold by non-insurance providers and, only indirectly affect the relationship between the insurance

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[10] Blue Cross/Blue Shield in Virginia and Oklahoma operate their prescription programs on a usual and customary fee basis. Other non-fixed fee third party prepaid prescription plans include the Iowa Pharmacy Service Corporation, Blue Cross/Blue Shield of New Jersey, New Jersey Medicaid, New Jersey Paid Rx, Veterans Administration, Allstate Insurance, and Minnesota Pharmaceutical Service Corporation. Numerous corporate and union plans are also offered on a non-fixed fee basis.

company and the insured, are the business of insurance within the meaning of the McCarran Act.

Group Life and *amici* filing in support of Group Life argue that provider contracts which set the fee to be paid a pharmacist and the price to be paid by the insured should fall within the McCarran Act because such contracts provide insurance companies with a cost containment mechanism. While the fixing of prices and fees may well provide a way to hold down insurance company costs, the ultimate legality of this or other cost containment practices is not before this Court, and, on its own provides no support for expanding the scope of the McCarran Act exemption. This Court has long held that because of its pernicious effect the motivation for price fixing is irrelevant. *Kiefer-Stewart v. Seagrams,* 340 U.S. 211, 213, (1951).

While various aspects of health care have shown significant cost increases in recent years, this is not the case with pharmacy fees. In those areas in which health care costs have increased significantly, Congress has passed or is considering legislation [11] and the Department of Health, Education and Welfare is considering various regulations.[12] Such federally mandated cost containment procedures are similar to the procedures imposed by the Commonwealth of Pennsylvania evident in the *Travelers Insurance Company* [13] and *Doctors, Inc.*[14] cases. Such state mandated pro-

[11] See, e.g., Social Security Act and Amendments, 42 U.S.C. §1320 (1975); Hospital Cost Containment Act of 1977, H.R. 6575 and S. 1391, 95th Cong. 1st Sess. (1977).

[12] See, e.g. 45 C.F.R. 19; Department of Health, Education and Welfare, Proposed Regulation 42 C.F.R. 450, published at 43 Fed. Reg. 20516 (May 12, 1978).

[13] Travelers Insurance Co. v. Blue Cross of Western Pennsylvania, 481 F.2d 80, 83-84 (3d Cir.) *cert. denied,* 414 U.S. 1093 (1973).

[14] Doctors, Inc. v. Blue Cross of Greater Philadelphia, 557 F.2d 1001 (3d Cir. 1976), *aff'g,* 431 F. Supp. 5, 10 (E.D. Pa. 1975).

cedures may well pass antitrust muster and can be used to accomplish cost containment in those situations in which a state or federal body determines it is necessary and in the public interest. This form of mandated regulation is the very type of balancing of interests which this Court has indicated is necessary before the antitrust laws are to be set aside.[15]

Such state mandated activity is vastly different from "cost containment" programs imposed on large segments of the economy by private parties with the primary interest of increasing their own profits. If cost containment is appropriate in this area, Congress or the states should impose it.

B. The Legislative History Of The McCarran Act Establishes That Activities With Non-Insurance Third Party Providers To Fix The Price Of A Non-Insurance Product Is Not Within The Business Of Insurance.

1. Introduction

The McCarran Act was enacted in 1945 in response to this Court's decision in *United States v. South-Eastern Underwriters Association,* 322 U.S. 533 (1944).[16] In *South-Eastern Underwriters,* the Court held that the busi-

[15] City of Lafayette v. Louisiana Power and Light Co., — U.S. —, 55 L.Ed.2d 364, 383-84 (March 29, 1978).

[16] In United States v. South-Eastern Underwriters Association, 322 U.S. 533 (1944), defendent association, defendants insurance companies and individual defendants were indicted for conspiring to fix insurance rates and commissions, and for conspiring to boycott and coerce other insurers, agents and insureds who did not accept defendants' policies. Defendant insurance companies, all fire insurance companies, accounted for 90 percent of fire insurance sold in six southeastern states. Defendants, not arguing the antitrust merits, contended that the business of insurance was not commerce and, therefore, not subject to antitrust law. The District Court agreed with defendants and dismissed the indictments. United States v. South-Eastern Underwriters Association, 51 F. Supp. 712 (N.D. Ga. 1943).

ness of insurance was "commerce" and, therefore, subject to federal regulation under the commerce clause.[17]

In so finding, the Court overruled a line of decisions which held that the business of insurance was not commerce. These decisions had followed the 1869 decision of *Paul v. Virginia*, 75 U.S. [8 Wall.] 168 (1869), which upheld a Virginia statute regulating foreign insurance companies doing business in Virginia.[18] Thereafter, courts upheld state regulation and taxation of the business of insurance, even if interstate commerce was involved. As such, regulation and taxation of the business of insurance was by the states, not the federal government.[19]

South-Eastern Underwriters threatened the continued existence of state regulation and taxation of the business of insurance. First, by holding the business of insurance to be commerce, it threatened the constitutionality of state regulation and taxation of the business of insurance.[20]

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[17] U.S. CONST. art. I, §8.

[18] The Court stated that ". . . issuing a policy of insurance is not a transaction of commerce." Paul v. Virginia, 75 U.S. [8 Wall.] 168, 183 (1869).

[19] *See Report of Subcommittee on Federal Legislation to Executive Committee of National Association of Insurance Commissioners* (Aug. 29, 1944), *reprinted at* 90 Cong. Rec. A4403-06 (Nov. 16, 1944) [hereinafter *"Report of National Association of Insurance Commissioners"*].

[20] Revenue from state taxation of the business of insurance was an important source of income to states. In 1942 the forty-eight states received $113,022,000 from taxation of insurance. 90 Cong. Rec. 6548 (June 22, 1944). After *South-Eastern Underwriters*, insurance companies refused to pay state taxes on the ground that that decision rendered state regulation and taxation unconstitutional. *See* S. Rep. No. 20, 79th Cong. 1st Sess. (Jan. 24, 1945); H.R. Rep. No. 143, 79th Cong., 1st Sess. (Feb. 13, 1945); 91 Cong. Rec. 478-79 (Jan. 25, 1945) (remarks of Senator Ferguson). The Attorney General of North Carolina agreed. He ruled that North Carolina could no longer tax insurance companies doing business in North Carolina. 91 Cong. Rec. 1085 (Feb. 14, 1945) (remarks of Representative Walter).

Second, it opened the door to express federal regulation of the business of insurance. Third, even without express federal regulation, state regulation and taxation was threatened with implicit preemption through the commerce clause by federal laws and regulations.[21]

As will be shown below, the initial, but not final, reaction of Congress to *South-Eastern Underwriters*, was to restore the status quo by exempting the business of insurance from the federal antitrust laws. Ultimately, as this Court found as recently as June 29, 1978 in *St. Paul Fire & Marine Insurance Co. v. Barry*, — U.S. —, 46 U.S.L.W. 4971, 4973 (June 29, 1978) the purpose of the McCarran Act was limited to allowing the states the right to regulate and tax the business of insurance, notwithstanding that the business of insurance involves interstate commerce. In each successive step of the legislative process, Congress narrowed the antitrust exemption for the business of insurance until it arrived at the very narrow exemption contained in the proviso clause of section 2(b) of the McCarran Act.[22]

The proviso clause provides that federal antitrust laws apply to the business of insurance to the extent that such business is not regulated by state law. That is, federal antitrust laws apply to activities of insurance companies unless the activities meet the following two prerequisites: (1) the activities must be within the business of insurance, and (2) the activities must be regulated by state law. If these two prerequisites are met, federal antitrust laws do not apply to such activities to the extent the state regulates such activities.

The Fifth Circuit found that the activities of petitioner Group Life and the participating pharmacists, who are

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[21] *See Report of National Association of Insurance Commissioners, supra* at A4404.

[22] 15 U.S.C. § 1012(b).

not insurance providers, which fixed the price of drugs sold to Group Life policyholders by participating pharmacists were not within the business of insurance. The correctness of that holding can be seen in light of, and is established by, the legislative history, policy and purpose of the McCarran Act.

The legislative history shows that the congressional purpose in enacting the McCarran Act in general and section 2(b) in particular was to accommodate two competing, and sometimes conflicting, statutory schemes, state insurance regulation and federal antitrust laws. Consistent with our Federalist system of state and national government, Congress chose to allow each to apply to the business of insurance. If, and to the extent, federal antitrust laws conflict with state insurance regulation, the federal antitrust laws are preempted. But, in further balance of that scale of accommodation, if the conflict involves the antitrust laws' prohibition against agreements and acts of boycott, coercion and intimidation, state insurance regulation is preempted.

Consistent with that purpose Congress intended the business of insurance to include only activities between and among insurance companies, their insureds, employees and agents, which were part of state insurance regulatory schemes. Beyond those activities constituting the business of insurance, Congress intended that federal law, including the federal antitrust laws, preempt state law in accordance with the commerce clause. Petitioners, in direct contradiction of this delicate balance of the McCarran Act and of the commerce clause, would contort the meaning of the "business of insurance" so as to expand its coverage to include petitioners' activities which fixed prices of a non-insurance product, pharmaceuticals, and thereby avoid application of the federal antitrust laws to those activities. But, the legislative history, policy and purpose of the McCarran Act establish that the Fifth Circuit's holding

is correct. Petitioners' activities are not within the business of insurance.

2. Congressional Reaction Evolved From Total Antitrust Exemption To Only Preserving State Regulation And Taxation Of The Business Of Insurance.

With an apparent ability to predict the Court's decision, legislation [23] to totally exempt the business of insurance from federal antitrust law was introduced prior to *South-Eastern Underwriters*. The operative language of the total exemption legislation was as follows:

> *Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That nothing contained in the Act of July 2, 1890, as amended, known as the Sherman Act, or the Act of October 15, 1914, as amended, known as the Clayton Act, shall be construed to apply to the business of insurance or to acts in the conduct of that business or in any wise to impair the regulation of that business by the several states.[24]

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[23] On September 20, 1943, Representative Hancock introduced H.R. 3269 and Representative Walter introduced H.R. 3270. On the following day, September 21, 1943, Senators Bailey and Van Nuys introduced S. 1362. All three bills totally exempted the business of insurance from antitrust law. Joint Senate and House hearings were held on H.R. 3269, H.R. 3270 and S. 1362. *See Joint Hearings Before the Subcommittees of the Committees on the Judiciary on S. 1362, H.R. 3269, and H.R. 3270,* 78th Cong., 1st and 2d Sess. 1 (1944). Joint hearings were held on October 20 and 27, 1943; November 3, 1943; December 3, 14, 15 and 21, 1943; March 30, 1944; May 26 and 27, 1944; and June 23, 1944. S. Rep. No. 1112, 78th Cong., 2d Sess (Sept. 20, 1944).

[24] H.R. 3270 and S. 1362 contained identical language and were introduced as companion bills. *See* 89 Cong. Rec. A5377 (Dec. 9, 1943) (remarks of Representative LaFollette). The full text of H.R. 3270 and S. 1362 is set forth in Appendix A.

The total exemption bills failed for several reasons.[25] First, and foremost, the total exemption bills were not supported by the National Association of Insurance Commissioners ("NAIC").[26] The NAIC favored a limited exemption to the states, not to insurance companies, only as broad as necessary to continue state regulation and taxation.[27] The NAIC was in the process of drafting a bill which it expected to have ready by September 1, 1944.[28] Opponents of the total exemption bills argued that Congress before acting should wait for the states to speak.[29]

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[25] Just over two weeks after this Court's decision in *South-Eastern Underwriters*, the House on June 22, 1944 passed H.R. 3270. 90 Cong. Rec. 6565 (June 22, 1944). However, the bill did not pass the Senate. On September 21, 1944 the Senate first passed, then reconsidered and passed over the bill. 90 Cong. Rec. 8054 (Sept. 21, 1944). Despite further efforts to pass a total exemption bill, none would again come as close as did H.R. 3270 on September 21, 1944.

[26] *See* letter dated November 22, 1944 to Senator Arthur H. Vandenberg from Michigan Insurance Commissioner David Forbes, *reprinted at* 90 Cong. Rec. 8482 (Nov. 28, 1944). The letter, in part, stated as follows:

> The Commissioners believe that the insurance business has no more right to ask for a blanket exclusion from these acts than any other business that has been held to be engaged in interstate commerce.

[27] *See Report of National Association of Insurance Commissioners, supra* at A4405; *Joint Statement of Newell R. Johnson, President, Edward R. Scheufler, Chairman of the Executive Committe, and Charles F.J. Harrington, Chairman of the Subcommittee on Federal Legislation of the National Association of Insurance Commissioners, reprinted at* 90 Cong. Rec. A4406 (Nov. 16, 1944) [hereinafter "NAIC Joint Statement"].

[28] Letter dated June 20, 1944 to Representative Clinton P. Anderson from the President of NAIC, Newell R. Johnson, *reprinted at* 90 Cong. Rec. 6420 (June 21, 1944).

[29] 90 Cong. Rec. 6420 (June 21, 1944); S. Rep. No. 1112, pt. 2, 78th Cong., 2d Sess. (Sept. 20, 1944) (Minority Report). The Minority Report at 6 noted as follows:

> The executive committee of the National Association of Insurance Commissioners has been called to meet in Chicago on September 29 and 30 for the purpose of implementing the

Significantly, while stock fire and casualty fire companies favored total exemption, life insurance companies and mutual fire and casualty companies did not. The latter favored the NAIC position.[30]

Another reason for the failure of the total exemption bills was the antipathy toward exempting any industry from the antitrust laws, and the fear that other industries would seek similar legislation. Coupled with this concern was the fear that once totally exempted, the insurance industry would prey upon small businesses and individual insureds.[31]

A final reason was the opposition, and threatened veto, of President Roosevelt.[32] The Department of Justice op-

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> declaration of principles unanimously adopted at St. Louis. . . . . Congress should accede to the request of this group and . . . no definite action should be taken until after these State officials have had an opportunity to present to the Congress the report upon which they are now working. *Surely it is a strange way for Congress to defend States rights by declining to await the specific recommendations of responsible State officials.* (Emphasis added).

[30] Letter dated November 22, 1944 to Senator Arthur H. Vandenberg from Michigan Insurance Commissioner David Forbes, *reprinted at* 90 Cong. Rec. 8482 (Nov. 28, 1944).

[31] *See e.g.*, the debates in the House of Representatives on June 21 and 22, 1944 with regard to H.R. 3270 printed at 90 Cong. Rec. 6449-6455 (June 21, 1944) and 90 Cong. Rec. 6521-6557, 6559-6565 (June 22, 1944); S. Rep. No. 1112, pt. 2, 78th Cong., 2d Sess (Sept. 20, 1944) (Minority Report); 90 Cong. Rec. 6455 (June 21, 1944) (remarks of Representative Poage).

[32] 91 Cong. Rec. 1087 (Feb. 14, 1945) (remarks of Representative Hancock). Representative Hancock, ultimately one of three House conferees, during the debate on the House version of S. 340, which became the McCarran Act cited to the threat of Presidential veto of the total exemption bill. He stated as follows:

> I was a strong supporter last year of the Walter bill [H.R. 3270]. . . . But we believe we cannot pass that bill as the Senate is now constituted, and we are told with some assurance that the President would veto it.

See 91 Cong. Rec. 1089 (Feb. 14, 1945) (remarks of Representative Anderson).

posed H.R. 3270 on the grounds that it would totally exempt the business of insurance; that it would interfere with pending criminal prosecutions; and that it was unnecessary to preserve state regulation in light of *Parker v. Brown*, 317 U.S. 341 (1943).[33] The Administration favored a moratorium on antitrust law during which the insurance industry could bring itself into compliance.[34]

Accordingly, Congress was not prepared to give the insurance industry a blanket exemption from the antitrust laws under which insurance companies would be free to engage in anticompetitive activities. Thus, as a threshold matter the McCarran Act is not, and never was intended to be, a total exemption from the antitrust laws.

As discussed above, the NAIC requested Congress not to pass the Walter total exemption bill, H.R. 3270, and to wait to consider a bill it was preparing. On August 29, 1944 the NAIC released its Report of the National Association of Insurance Commissioners.[35] That Report made four specific recommendations regarding new legislation.[36]

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[33] H.R. Rep. No. 873, 78th Cong., 1st Sess. (Nov. 18, 1943); S. Rep. No. 1112, 78th Cong., 2d Sess. (Sept. 20, 1944).

[34] Letters dated June 10, 1944 and January 2, 1945 to Senator George L. Radcliffe from Franklin D. Roosevelt, President of the United States, *reprinted at* 91 Cong. Rec. 482 (Jan. 25, 1945).

[35] *Reprinted at* 90 Cong. Rec. A4403-06 (Nov. 16, 1944).

[36] First, to deal with the commerce clause problem it recommended legislation affirmatively establishing that the regulation and taxation of the business of insurance by states continue. Second, it recommended that the Federal Trade Commission Act be amended so as to eliminate from its scope the business of insurance. Third, it recommended that the Robinson-Patman Act be amended so as to eliminate from its scope the business of insurance. Fourth, it recommended that the Sherman Act and Clayton Act be amended to permit the business of insurance to engage in ". . . all reasonable and cooperative procedures necessary and incidental to the establishment of statistical rate bases, rates, coverages and related matters." *Id.* at A4405.

The key recommendation, and what was to be the central theme of the McCarran Act, was that Congress enact legislation under the commerce clause that secured to the states the right to continue regulating and taxing the business of insurance. The remaining three recommendations were with respect to federal antitrust laws. Each sought to effectuate, with respect to certain specifics, the ability of states to regulate and tax the business of insurance. Thus, the second recommendation that the Federal Trade Commission Act[37] be amended to eliminate jurisdiction over the business of insurance was urged to eliminate the possibility that the Federal Trade Commission would preempt state regulation. Similarly, the recommendation to amend the Robinson-Patman Act[38] stemmed from a fear that "commodities" would be strained to include insurance and, thereby, outlaw broker commissions. The last recommendation, which was to amend the Sherman Act[39] and Clayton Act[40] to allow cooperative practices, reflected the form of much state regulation, which not only allowed cooperative practices, but often required it. For purposes of understanding the meaning of the "business of insurance," it is significant to note that in seeking amendment of the Sherman Act and Clayton Act, the NAIC sought to preserve cooperative activities between and among insurance entities.[41]

Accordingly, from the outset the purpose of the NAIC, which represented the state insurance commissioners, was

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[37] 15 U.S.C. §41 *et seq.* (1970).

[38] 15 U.S.C. §13-13b, 21a (1970).

[39] 15 U.S.C. §1 *et seq.* (1970).

[40] 15 U.S.C. §12 *et seq.* (1970).

[41] The *Report of the National Association of Insurance Commissioners* noted that "[t]o prohibit combined efforts for statistical and rate-making purposes would be a backward step in the development of a progressive business." 90 Cong. Rec. A4405 (Nov. 16, 1944).

to protect the continued regulation and taxation by states of the business of insurance, and not to exempt that business from the antitrust laws. The three recommendations regarding the antitrust laws were for the limited purpose of curing antitrust prohibitions against specific practices, such as cooperative rate-making, which were part of the state regulatory schemes. The recommendations only concerned activities within and among the insurance industry. No suggestion was made to include within the business of insurance activities with non-insurance entities, such as pharmacists.[42]

On November 16, 1944, the NAIC released the text of its proposed bill.[43] Section 2(a) of the NAIC bill specifically provided that "[t]he business of insurance . . . shall be subject to the laws of the respective states which relate to the regulation of such business and which impose fees or taxes thereon."[44] The bill provided in section 2(b) that no federal act will invalidate, impair or supersede state law regulating the business of insurance unless the federal act specifically so provides.[45] Section 3 provided that neither the Federal Trade Commission Act nor the Robinson-Patman Act would apply to the business of insurance.

Section 4, which was subdivided into three parts, (a), (b) and (c), dealt with the Sherman and Clayton Acts. Subsection (a) contained a moratorium prohibiting the application of the two Acts to the business of insurance until July 1, 1948. Subsection (b) enumerated seven specific acts which would not be prohibited by the Sherman Act.[46] Finally subsection (c) provided that the Sherman Act prohibition against acts of boycott, coercion, or intimidation would apply to the business of insurance. Subsection (c), in effect, made two limitations. First, it limited the moratorium to acts other than of boycott, coercion, or intimidation. Second, it limited a state's right as provided by section 2(b) to preempt federal antitrust laws. A state could not regulate inconsistently with the Sherman Act's prohibition against acts of boycott, coercion or intimidation.

[42] The *Report of the National Association of Insurance Commissioners* emphasized that in recommending relief from the Sherman Act and Clayton Act it was not ". . . condoning any oppressive or destructive practices." *Id.*

[43] 90 Cong. Rec. A4406 (Nov. 16, 1944). The full text of the NAIC bill is set forth at Appendix B.

[44] *Id.*

[45] Section 2(b) was the forerunner of the first part of section 2(b) of the McCarran Act.

On January 18, 1945, McCarran and Ferguson introduced the NAIC bill, as amended by the deletion of the enumerated practices of section 4(b), which received the designation S. 340.[47] It was S. 340, as amended, that President Roosevelt signed into law on March 9, 1945.

One week after being introduced, the Senate Committee on the Judiciary reported S. 340 to the Senate. That same day it was debated and passed with two amendments.[48] The first amendment added a prohibition against *agreements* to boycott, coerce or intimidate to section 4(b) which already prohibited *acts* of boycott, coercion or intim-

[46] Subsequently, it was eliminated because of concern that enumerating specific practices was too rigid. The drafters of subsection 4(b) foresaw this problem. *The Memorandum of Explanation of Proposed Text of Legislation* with regard to subsection 4(b) states as follows:

> It is within the realm of possibility that other legitimate practices in the business which are not specified should have express recognition.

Id. at A4407.

[47] Senators McCarran and Ferguson initially introduced the bill on December 19, 1944. But the 78th Congress never acted on it. The full text of S. 340 as introduced is reprinted herein at Appendix C.

[48] 91 Cong. Rec. 488 (Jan. 25, 1945).

idation.[49] The effect of that amendment was to further limit a state's power to preempt the federal antitrust laws.

The second amendment concerned section 2(b).[50] The debate with regard to section 2(b) concerned the extent to which state law under section 2(b) could preempt the Sherman and Clayton Acts. It provided as follows:

> (b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such act specifically so provides.[51]

The problem was whether section 2(b) meant that since the Sherman and Clayton Acts did not specifically provide that each applied to the business of insurance, state law superseded each.[52] Proponents for the supremacy of the Sherman and Clayton Acts over state law prevailed, and section 2(b) was amended to except the Sherman and Clayton Acts from it.[53] As passed by the Senate, section 2(b) of S. 340 read, with the amendment in italics, as follows:

> (b) No act of Congress, *except the act of July 2, 1890, as amended, known as the Sherman Act, and/or the act of October 15, 1914, as amended, known as the Clayton Act,* shall be construed to invalidate, impair, or supersede any law enacted by

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[49] This amendment was recommended by the Senate Committee on the Judiciary. S. Rep. No. 20, 79th Cong., 1st Sess. (Jan. 24, 1945). The bill, as reported out of the Committee, is printed at 91 Cong. Rec. 478 (Jan. 25, 1945).

[50] Section 2(b) of S. 340 had remained as drafted by the NAIC.

[51] 91 Cong. Rec. 478 (Jan. 25, 1945).

[52] *See* 91 Cong. Rec. 478-88 (Jan. 25, 1945).

[53] The amendment was offered by Senator Ferguson. 91 Cong. Rec. 486 (Jan. 25, 1945).

> any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such act specifically so provides. (Emphasis added).

91 Cong. Rec. 488 (Jan. 25, 1945).

On February 13, 1945, the House Committee on the Judiciary reported S. 340 with the Committee's amendments to the House.[54] The Committee amended S. 340 by returning section 2(b) to its original language without the amendment excepting the Sherman and Clayton Acts; amending section 4(a) to delete the precatory language expressing that section's purpose;[55] amending section 4(a) to make the Sherman Act moratorium extend to January 1948, which was the date the Clayton Act moratorium extended to; and returning section 4(b) to its original language by deleting the word *agreement* so that the subsection only prohibited "any act of boycott, coercion, or intimidation."[56]

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[54] S. 340, as amended by the House Committee on the Judiciary, was designated H.R. 1973. 91 Cong. Rec. 978 (Feb. 9, 1945) (remarks of Representative Walter).

[55] Section 4(a), as passed by the Senate, read with the language deleted by the House Committee on the Judiciary, in italics, as follows:

> Sec. 4(a) *For the purpose of enabling adjustments to be* made and legislation to be adopted by the *several States and Congress,* until June 1, 1947, the act of July 9, 1890, as amended, known as the Sherman Act, shall not apply to the business of insurance, or to act in the conduct of such business, and until January 1, 1948, the act of October 15, 1914, as amended, known as the Clayton Act, shall not apply to such business or to acts in the conduct thereof. (Emphasis added).

91 Cong. Rec. 488 (Jan 25, 1945).

[56] The text of S. 340, as amended and reported to the House by the Committee on the Judiciary, may be found at either 91 Cong. Rec. 1085 (Feb. 14, 1945) or H.R. Rep. No. 143, 79th Cong, 1st Sess. (Feb. 13, 1945).

The House passed S. 340 as amended by its Committee on the Judiciary on February 14, 1945.[57] In so doing, the House understood that at Conference Committee the limited preemption right contained in S. 340 was to be narrowed further and that the exemption from the Robinson-Patman and Federal Trade Commission Acts contained in section 3 was to be eliminated. First, the deleted prohibition against any *agreement* of boycott, coercion, or intimidation was to be reinstated at Conference Committee.[58] The effect of this change was to further limit the ability of the states to regulate in conflict with the Sherman Act.[59] Second, the *exemption* from the Robinson-Patman and Federal Trade Commission Acts contained in section 3 was deleted. Instead, each was included in the moratorium provision.[60] The effect of the deletion of

[57] The House debate of S. 340 on February 14, 1945 is at 91 Cong. Rec. 1085-1094 (Feb. 14, 1945).

[58] During the debates Representative Celler informed the House that the Attorney General of the United States opposed the House version of S. 340 because subsection 4(b) did not prohibit agreements of boycott, coercion and intimidation. Representative Cellar stated as follows:

> I asked him [the Attorney General] why [he was opposed] and he said he was opposed to it because there was stricken from the bill language which would proscribe and make unlawful not only acts to intimidate, boycott and to coerce but also agreements to coerce and to boycott.

91 Cong. Rec. 1086 (Feb. 14, 1945). Representative McCormack then asked Representative Walter, ultimately one of three House conferees, if he would reinstate the agreement language at Conference Committee. Representative Walter agreed. 91 Cong. Rec. 1088 (Feb. 14, 1945). As passed by the Senate, S. 340 already contained the prohibition against such agreements.

[59] The reinstatement of *agreement* expanded the scope of section 4(b), which ultimately became section 3(b) of the McCarran Act. Since section 3(b) limited the state's preemption right provided in section 2(b), expanding 3(b) had the effect of limiting a state's right to preempt federal antitrust laws.

[60] Section 3 had remained intact from the first version of the NAIC bill introduced on November 16, 1944. The purpose of section 3 was first, to permit the states to continue to regulate certain practices feared violative of the Robinson-Patman Act and, second, to prevent the Federal Trade Commission from preempting state regulation of the business of insurance. The purpose of section 3 was not to immunize insurance companies from the Robinson- Patman and Federal Trade Commission Acts. Nevertheless, since section 3 provided an *exemption*, it did exactly that; it immunized insurance companies from the Robinson-Patman and Federal Trade Commission Acts. *See, e.g.*, 91 Cong. Rec. 1027-28 (Feb. 12, 1945) (remarks of Representative Cochran). Representative Kefauver sought and received the agreement of Representative Sumners, another of the three House conferees, that at Conference Committee section 3 would be eliminated, and the Robinson-Patman and Federal Trade Commission Acts would be included in the moratorium provisions of subsection 4(a). 91 Cong. Rec. 1092-93 (Feb. 14, 1945). After January 1, 1948, these Acts would be subject to the *preemption* provision of subsection 2(b).

section 3 was to remove the last provision which would have conferred on the insurance industry antitrust immunity. The deletion of section 3 meant that S. 340 solely pertained to the right of states to regulate and tax the business of insurance.

The Conference Committee,[61] in reconciling the differences between the House and Senate versions of S. 340, made two important changes. First, section 3 was deleted and the Robinson-Patman and Federal Trade Commission Acts were incorporated into the moratorium provision of section 4(a).[62] Second, section 2(b) was redrafted to eliminate the language excepting the Sherman and Clayton Acts and substituting, in lieu thereof, language which made the Sherman and Clayton Acts ". . . applicable to the business of insurance to the extent that such business is

[61] The House conferees were Hatton W. Sumners of Texas, Francis E. Walter of Pennsylvania, and C. E. Hancock of New York. The Senate conferees were Pat McCarran of Nevada, Joseph C. O'Mahoney of Wyoming, and Homer Ferguson of Michigan. H.R. Rep. No. 213, 79th Cong., 1st Sess. (Feb. 22, 1945) (Conference Report).

[62] With the deletion of section 3, each following section was renumbered. Thus, section 4(a) of S. 340 became section 3(a) of the McCarran Act.

not regulated by state law."[63] The Conference Committee version of S. 340 became the McCarran Act.[64]

In sum, the Congressional response to *South-Eastern Underwriters* evolved from total exemption bills to the McCarran Act. That is, from giving the insurance industry complete and total immunity from the federal antitrust laws to providing that the states could preempt federal antitrust laws to the limited extent such federal law conflicted with state insurance regulation. That preemption right was limited. States could not preempt the Sherman Act prohibition against agreements or acts of boycott, coercion or intimidation. The insurance industry itself received no antitrust immunity. Activities of insurance companies were only immune if within the business of insurance and regulated by state insurance law. Moreover, that immunity was only to the extent the activities were regulated by state insurance law.

3. The Legislative History Of The McCarran Act Establishes That The Business Of Insurance Does Not Include Activities Restraining Competition In Non-Insurance Markets.

a. Introduction

As the foregoing review of its legislative history establishes, the purpose of the McCarran Act was to allow the states to regulate and tax the business of insurance. To effectuate that purpose, section 2(b) of the Act provides that federal antitrust laws, except with respect to agreements or acts of boycott, coercion, or intimidation, do not apply to the business of insurance to the extent that the

[63] H.R. Rep. 213, *supra* at 2.

[64] The House on February 23, 1945, without debate, passed the Conference Committee version of S. 340. 91 Cong. Rec. 1396 (Feb. 23, 1945). Four days later, on February 27, 1945, the Senate, after debate, passed the Conference Committee version of S. 340. 91 Cong. Rec. 1489 (Feb. 27, 1945). On March 9, 1945 President Roosevelt signed it. 91 Cong. Rec. 1992 (March 12, 1945).

state regulates that business. Review of the legislative history of section 2(b) reveals that it, like the Act itself, evolved from a broad repeal of federal antitrust laws to a narrow preemption right tailored to meet existing state insurance regulatory schemes. Consistent with that evolution and the Act's accommodation of both state insurance regulation and federal antitrust laws, the legislative history establishes that the "business of insurance" encompasses only acts between and among insurance entities, such as cooperative rate making and statistical gathering, then at the heart of state insurance regulatory schemes. Moreover, the legislative history of section 2(b) establishes that the "business of insurance" did not include activities with, or in restraint of competition between, non-insurance third parties.

b. Section 2(b) of the McCarran Act.

Section 2(b) of the McCarran Act may be divided into two distinct parts. The first part addresses the problem of implicit federal preemption of state regulation by eliminating the possibility. It provides that there be no implicit federal preemption by legislating that federal law not be construed to invalidate, impair or supersede state laws regulating or taxing insurance, unless the federal statute expressely so provides. This first part had its genesis in the original NAIC bill. The *Memorandum of Explanation of Proposed Text of Legislation* released by the NAIC jointly with the NAIC bill explains, in part, this language as follows:

> Subsection (b): This subsection further implements the earlier expression of the Congressional policy and will, and is designed to eliminate or at least minimize conflict between State laws and existing and further acts of Congress and perhaps more important, to furnish a guide to the courts in

any litigation which may ensue as to just what the Congress intended.[65]

The second part, the proviso clause, provides that federal antitrust laws apply to the business of insurance except to the extent that business is regulated by state law. Its origins are in the January 25, 1945 Senate debate of the first part of section 2(b).

The NAIC bill, as introduced by Senators McCarran and Ferguson, designated S. 340 and reported to the Senate by its Committee on the Judiciary retained the NAIC bill's language. Thus, on January 25, 1945, when the Senate debated S. 340, section 2(b) did not contain the proviso clause, and it read as follows:

> (b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such act specifically so provides.[66]

During the debate, it was realized that section 2(b) could be read, once the section 4(a) moratorium expired on January 1, 1948, to allow states to permit monopolies or monopolistic practices. This anomaly resulted from the fact that the antitrust laws did not expressly relate to the business of insurance.[67] Senator Taft, addressing the point, stated as follows:

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[65] 90 Cong. Rec. A4407 (Nov. 16, 1944).

[66] 91 Cong. Rec. 478 (Jan. 25, 1945).

[67] Section 2(b) may not have orginally contemplated the federal antitrust laws. S. 340 retained section 2(b) in the same form as drafted in the NAIC bill. In expressing the purpose of section 2(b) the NAIC did not even refer to antitrust law. Rather, it addressed the problem of state licensing of insurance companies, the states lack of power to do so with respect to interstate commerce, and the necessity of preserving the states' right to license. The NAIC's *Memorandum of Explanation of Proposed Text of Legislation* explains, in part, the purpose of section 2(b) as follows:

> One of the pillars, if not the keystone of State regulation, is the licensing power. The United States Supreme Court, in interpreting the commerce clause of the Constitution, has held many times that no State can insist that an individual or other person obtain a license as a condition precedent to the transaction of interstate business. . . .
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> * * *
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> It is to be hoped at least, that a declaration of congressional policy and will, combined with the fact that the licensing system has been in use in the field of State insurance regulation since its inception several decades ago, will result in a determination by the United States Supreme Court, if the subject is ever reviewed, that the rule followed in the cases cited will not be applied to the insurance business and that licensing be continued. (Citations omitted).

90 Cong. Rec. A4407 (Nov. 16, 1944).

[68] 91 Cong. Rec. 485 (Jan. 25, 1945) (remarks of Senator Taft).

> In section 4(a) of the bill it is implied that in 1948 the Sherman Act shall again come into force unless something has been done in the meantime. However, in section 2(b) it is implied that even in 1948 the Sherman Act shall not invalidate any State regulatory law.[68]

As this Court noted in *St. Paul Fire & Marine Insurance Co. v. Barry, supra* at 4975 n.20, Senator O'Mahoney, ultimately one of the three Senate conferees, also understood that section 2(b) was not intended to apply to the antitrust laws. Senator O'Mahoney had introduced a bill designated S. 12 which was virtually identical to S. 340, and was identical to S. 340 with respect to section 2(b). In the January 25, 1945 debate on S. 340 he stated as follows:

> Section 2(b) was drafted and written into the bill which I introduced, in the belief, not that it would be interpreted as an additional exemption from the antitrust laws, but that it would be a sort of catch-all provision to take into consideration other acts of Congress which might affect the insurance industry, but which we did not have knowledge at the time.

91 Cong. Rec. 483 (Jan. 25, 1945). By "other acts of Congress" Senator O'Mahoney meant other than the antitrust laws.

Senator Ferguson, co-sponsor of S. 340 and also ultimately one of the three Senate conferees, confirmed that section 2(b) was intended to apply federal laws pertaining to regulation of interstate commerce. He stated that section 2(b) ". . . provides that no Federal legislation relating to interstate commerce shall by implication repeal any existing law unless such act of Congress specifically so provides." *Id.*

Since section 2(b) was not intended to apply to the federal antitrust laws, the problem was solved by expressly excepting such laws from section 2(b). Thus, Senator Ferguson offered an amendment, which was adopted and then passed with S. 340, that amended section 2(b) to except the Sherman and Clayton Acts from its terms. Section 2(b) of S. 340, as passed by the Senate with the Ferguson Amendment on January 25, 1945, read as follows:

> (b) No act of Congress, *except the act of July 2, 1890, as amended, known as the Sherman Act, and/or the act of October 15, 1914, as amended, known as the Clayton Act,* shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such act specifically so provides. (Ferguson amendment in italics.)

91 Cong. Rec. 488 (Jan. 25, 1945).

The problem with the Ferguson amendment is that it went too far. In its original form section 2(b) was objectionable because it would have allowed the states to preempt federal antitrust laws without regard to whether federal antitrust laws interferred with state insurance regulation. Amended section 2(b), as passed by the Senate,

did the opposite. It had the effect of preempting state regulation wherever such regulation conflicted with the antitrust laws.

The principle House debate of its version of S. 340 occurred on February 14, 1945.[69] As reported to the House by its Committee on the Judiciary, S. 340 did not contain any of the Senate amendments, including the Ferguson amendment.[70] The reason why the Committee reported to the House as it did, was that S. 340, as introduced, represented a compromise among various factions, and the House Committee was loathe to deviate from that compromise.[71] The Ferguson amendment was not discussed in any of the House debates which culminated in the passage on February 14, 1945 of S. 340 as reported by the House Committee.

Accordingly, the Senate and House went to conference with conflicting sections 2(b). The Senate version of section 2(b) allowed federal antitrust laws to preempt state laws regulating insurance. The House version allowed state insurance laws to preempt federal law unless federal law expressly provided otherwise. What emerged was a new addition to section 2(b), the proviso clause. What that clause did was to *expressly* make the Sherman, Clayton and Federal Trade Commission Acts apply to the business of insurance, but only to the extent that the business of insurance is not regulated by state law. It was, and is, completely consistent with the view that the federal antitrust laws should apply to the insurance industry, but that the states should be able to continue to regulate that industry. It provided no immunity to insurance companies, but did

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[69] *See* 91 Cong. Rec. 1085-94 (Feb. 14, 1945).

[70] *See* 91 Cong. Rec. 1085 (Feb. 14, 1945).

[71] *See* 91 Cong. Rec. 978-79 (Feb. 9, 1945) (remarks of Representative Walter); 91 Cong. Rec. 1085-86 (Feb. 14, 1945) (remarks of Representative Walter).

allow states to mandate certain activities which but for that state action would be subject to federal antitrust laws.

c. The Legislative History Establishes That Petitioners' Activities Are Not Within The Business Of Insurance.

As the foregoing review of the McCarran Act in general, and section 2(b) in particular reveals, the entire thrust of Congressional reaction to *South-Eastern Underwriters* was to accommodate two competing needs. The first, and foremost, was to allow the states to continue to regulate and tax the business of insurance. The second was to apply federal antitrust laws to the business of insurance, but only to the extent that such antitrust laws did not interfere with state regulation of the business of insurance.[72] Section 2(b) as passed satisfied both needs.

Petitioners urge a contorted reading of the "busines of insurance," which in effect destroys that delicate balance between state insurance regulation and federal antitrust laws. Petitioners' interpretation of the meaning of the business of insurance is of whole cloth. It is contrary to the plain meaning of the words as well as the clear legislative history of the McCarran Act, section 2(b) of that Act, and the "business of insurance" language contained in the proviso clause of that section.

As this Court just stated with respect to another section of the McCarran Act in *St. Paul Fire & Marine Insurance Co. v. Barry, supra* at 4974, "[t]he starting point in any case involving construction of a statute is the language itself." The "business of insurance" has a clear straightforward meaning. As this Court noted in *St. Paul Fire &*

[72] As previously noted, that ability is limited by section 3(b) which provides that there be no limitation upon the Sherman Act prohibition against agreements or acts of boycott, coercion, or intimidation. See H.R. Rep. No. 143, 79th Cong., 1st Sess. (Feb. 13, 1945).

Marine Insurance Co. v. Barry, supra, and stated in *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969), the business of insurance involves "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement." The activities of petitioners which fix the price of a non-insurance product, drugs, are not within the plain meaning of the "business of insurance."

Moreover, the legislative history clearly establishes that the "business of insurance" had a clear straightforward meaning to the drafters of the McCarran Act. They understood that business to include, and intended it to include, activities between and among insurance entities. Moreover, that legislative history establishes that Congress clearly understood from the indictments in *South-Eastern Underwriters* that certain existing practices between and among insurance companies violated federal antitrust laws. It was these intra-insurance industry activities that Congress in section 2(b) sought to allow the states to mandate.

The NAIC, in its Report and draft legislation, described activities within the business of insurance only in terms of activities between and among insurance companies, their insureds, employees and agents. From the outset, the states as represented by the NAIC were concerned that they be allowed to continue to require insurance companies to engage in cooperative activities. Thus, as previously discussed, the initial NAIC statement, the *Report of National Association of Insurance Commissioners,* sought to amend the Sherman and Clayton Acts to allow ". . . all reasonable cooperative procedures necessary and incidential to the establishment of statistical rate bases, rates, coverages and related matters."[73] The *Report* went on to conclude that ". . . it would be a mistake to permit or require the unrestricted competition contemplated by the antitrust laws

[73] 90 Cong. Rec. A4405 (Nov. 16, 1944).

to apply to the *insurance business*. To *prohibit combined efforts for statistical and rate-making purposes* would be a backward step in the development of a progressive business."[74] (Emphasis added.)

The original NAIC bill of November 16, 1944 in section 4(b) enumerated seven specific practices to which the Sherman Act was not to apply. *Each involved cooperative or concerted activities between and among insurance companies*. None involved practices which restricted or involved entities other than those engaged in providing insurance. If the NAIC contemplated allowing insurance companies to engage in activities with entities not providing insurance, it did not provide for such in its draft legislation.

The actions of the states immediately after passage of the McCarran Act confirm that the business of insurance constitutes activities between and among insurance companies, their insureds, employees and agents. By 1949 almost every state had passed state insurance regulations establishing procedures for cooperative rate making.[75]

The Congressional debates and reports of the House and Senate Committees on the Judiciary indicate that their concern was to allow the states the right to regulate the business of insurance so as to allow the continuation of the cooperative activities between and among insurance companies deemed desirable by the states. Senator Ferguson made this point absolutely clear when he stated that "[t]his bill (*i.e.*, S. 340 as ultimately passed) would permit — and I think it is fair to say that it is *intended* to permit, rating bureaus. . ."[76] Moreover, as this Court

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[74] *Id.*

[75] *See* W. Freedman, *Richards on the Law of Insurance* §52 (5th ed. 1952); Rose, *State Regulation of Property and Casualty Insurance Rates*, 28 Ohio St. L. Rev. 669 (1967).

[76] 91 Cong. Rec. 1481 (Feb. 27, 1945) (remarks of Senator Ferguson) (Emphasis added).

recognized in *St. Paul Fire & Marine Insurance Co. v. Barry, supra* at 4976 n.21., Senator O'Mahoney in explaining the meaning of the proviso clause specifically identified rating bureaus as an example of one activity within the business of insurance which would be permitted if mandated by a state.[77] What the proviso clause sought to prevent was private activities in restraint of trade, such as those of petitioners.[78]

Moreover, President Roosevelt in signing S. 340 into law specifically recognized the competing interests of state insurance regulation and the federal antitrust laws, and the accommodation of each achieved in section 2(b). He, like Senator O'Mahoney, focused upon the fact that the proviso clause prevented private activities in restraint of trade. President Roosevelt stated as follows:

> After the moratorium period, the antitrust laws and certain related statutes will be applicable in full force and effect to the business of insurance except to the extent that the States have assumed the responsibility, and are effectively performing that responsibility, for the regulation of whatever aspect of the insurance business may be involved . . . Congress did not intend to permit private rate fixing, which the Antitrust Act forbids, but was willing to permit actual regulation of rates by affirmative action of the States.

S. Rosenman, *The Public Papers of Franklin D. Roosevelt* 587 (1950).

Significantly, not only was the business of insurance contemplated only in terms of activities between and among those providing insurance, but also Congress under-

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[77] 91 Cong. Rec. 1444 (Feb. 26, 1945) (remarks of Senator O'Mahoney).

[78] 91 Cong. Rec. 1483 (Feb. 27, 1945) (remarks of Senator O'Mahoney).

stood "insurance" to be something entirely different from that engaged in by petitioners. Senator Ferguson explained what "insurance" meant to him. He said as follows:

> The sale of insurance is not the same as the sale of an article in a store. When one buys an article in a store, he brings it home with him. In the case of insurance, he buys a promise to pay upon the happening of a certain event, and that event may be the burning of his home. If the company is not sound and solvent at the time the house burns, or at the time claim is made, there is no insurance at all. That is what we have tried to avoid.

91 Cong. Rec. 1481 (Feb. 27, 1945).

Congress never considered the then infant Blue Cross and Blue Shield prepaid third party provider plans in connection with the McCarran Act. To Congress the business of insurance involved ". . . the distribution of risk according to hazard, experience, and the laws of averages."[79]

Congress never contemplated that section 2(b) could be used to validate restraints of trade imposed by one party, with and upon another who is a provider of services and commodities, and is wholly outside that of the business of insurance. Congress never contemplated that the meaning of the "business of insurance" could be contorted to include such restraints thereby destroying the delicate balance between state insurance regulation and federal antitrust laws it had fashioned.

The legislative history of the McCarran Act, its evolution as well as its purpose, therefore, establish that the Fifth Circuit was correct when it held that petitioners' activities are not within the "business of insurance."

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[79] H.R. Rep. No. 873, 78th Cong., 1st Sess. 8-9 (Nov. 18, 1943).

C. This Court's Interpretation of This Exemption and Other Exemptions From The Antitrust Laws Supports The Decision Of The Fifth Circuit.

As this Court has stated, Congress was primarily concerned in enacting the McCarran Act with insurance rate-making and the power of the state to tax insurance companies.[80] The Act was designed to assure the states a free hand in regulating the dealings between insurance companies and between insurers and their policyholders. Group Life argues that its contracts with pharmacy providers affects its reliability as an insurer and is therefore in the same class as other activities directly related to the relationship between the insurer and the insured. This interpretation of the statute is wholly unwarranted given this Court's prior determinations. As the Fifth Circuit found, policyholders have no interest in the way in which an insurer fulfills its obligations under the policy.[81]

The policyholders only interest is in the amount they must pay as co-pay. The price the insurer pays is not the concern of the policyholder. Thus, the primary effect of the provider contracts is on the relationship between pharmacists and insurers and on competition among pharmacists. While there may be an indirect effect on the rate the sponsor of the plan pays, based on the insurers ability to limit its costs, nothing in this Court's prior interpretations of the Act suggest that such an attenuated relationship justifies extending an antitrust exemption.[82]

This Court's interpretation of other exemptions from

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[80] SEC v. National Securities, Inc., 393 U.S. 453, 458-59 (1969).

[81] Royal Drug, *supra*, 556 F.2d at 1381.

[82] Taken to its logical conclusion, Petitioners' position could be used to justify an insurance company's activities in fixing the price of such goods as paper clips and typewriter ribbons because of the relationship between its costs of supplies and its rates. In fact, Petitioners' position means that there are no activities engaged in by insurance companies which are not exempt.

the antitrust laws supports rejection of Group Life's attempt to broaden the McCarran Act exemption. In recent years, this Court has dealt with exemptions from the antitrust laws involving labor unions,[83] agricultural cooperatives,[84] non-profit institutions,[85] regulated industries,[86] professions,[87] and state or municipal agencies.[88] In these cases, the Court has consistently upheld the principle that statutes exempting segments of the economy from the antitrust laws are to be narrowly construed. In each of these cases the Court examined the purpose of the exemption and determined that the purpose of the exemption did not require, and, therefore, the overriding importance of the antitrust laws did not permit an interpretation of the exemption which would expand the scope of activities which would be exempted from review under the antitrust laws beyond those clearly contemplated by Congress in creating the exemption. As we have shown, Congress never contemplated that the McCarran Act would encompass arrangements between retail pharmacists and insurance companies establishing the retail price at which pharmacists would sell prescriptions.

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[83] Connell Construction Co. v. Plumbers and Steamfitters Local Union No. 100, 421 U.S. 616, 622 (1975).

[84] National Broiler Marketing Association v. United States, 46 U.S.L.W. 4620 (June 12, 1978).

[85] Abbott Labs. v. Portland Retail Druggists Association, Inc. 425 U.S. 1 (1976).

[86] FMC v. Seatrain Lines, Inc. 411 U.S. 726 (1973).

[87] Goldfarb v. State Bar of Virginia, 421 U.S. 773 (1975), National Society of Professional Engineers v. United States, — U.S —, 55 L.Ed.2d 637 (April 25, 1978).

[88] City of Lafayette v. Louisiana Power & Light, — U.S. —, 556 L.Ed.2d 364 (March 29, 1978); Cantor v. Detroit Edison Co., 428 U.S. 579 (1976).

CONCLUSION

By seeking a broad definition of the term "the business of insurance," Group Life seeks to exempt from antitrust review activities involving pharmacists and insurance companies which set the price of retail drugs. The legislative history of the McCarran Act makes it clear that Congress never contemplated exempting activities carried on by insurance companies with non-insurance companies. Group Life would turn the limited right of the states to regulate the business of insurance provided by the McCarran Act into a right of private parties to set the price of goods and services in non-insurance segments of the economy in order to lessen their costs. This definition of the business of insurance goes far beyond the Court's prior interpretations of that term and is at total variance with this Court's consistent position that antitrust exemptions are to be narrowly construed.

Accordingly, the Fifth Circuit's decision should be affirmed.

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APPENDIX A

"TOTAL EXEMPTION BILL" S. 1362

(78th Cong. 1st Sess., Sept. 15, 1943)

To affirm the intent of the Congress that the regulation of the business of insurance remain within the control of the several States and that the Acts of July 2, 1890, and October 15, 1914, as amended, be not applicable to that business.

Whereas prior and subsequent to the Acts of July 2, 1890, and October 15, 1914, the business of insurance was and has been, and is now, regulated by the several States; and

Whereas, as a matter of local concern, the several States, respectively, each as it deems for the best interest of its citizens, do regulate all acts of insurance companies performed within their respective borders; and

Whereas it has not been, nor is it now, the intent or the desire of the Congress to invade the rights of the States or to assume to itself functions which have long been accepted as best performed by the States; and

Whereas there is now no need, through a Federal bureau or otherwise, for the Congress to displace or encumber the regulation by the States of the business of insurance; and

Whereas it has not been, nor is it now, the intent of the Congress that the Acts of July 2, 1890, and October 15, 1914, as amended, be construed as applying to the business of insurance or as impairing the regulation of that business by the States; and

Whereas it is in the public interest that Congress affirm its intent and desire and safeguard the States in the regulation of the business of insurance: Now, therefore,

Be it enacted by the Senate and House of Representatives of the United States of America in Congres assembled, That nothing contained in the Act of July 2, 1890, as amended, known as the Sherman Act, or the Act of October 15, 1914, as amended, known as the Clayton Act, shall be construed to apply to the business of insurance or to acts in the conduct of that business or in any wise to impair the regulation of that business by the several States.

APPENDIX B

"NAIC PROPOSED BILL"

(November 11, 1944)

That the Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation of such business by the several States.

SEC. 2.(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the respective States which relate to the regulation of such business and which impose fees or taxes thereon.

(b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such act specifically so provides.

SEC. 3. Nothing contained in the Federal Trade Commission Act, as amended, or the act of June 19, 1936, known as the Robinson-Patman Antidiscrimination Act, shall apply to the business of insurance or to acts in the conduct of that business.

SEC. 4.(a) Until July 1, 1948, the act of July 2, 1890, as amended, known as the Sherman Act, and the act of October 15, 1914, as amended, known as the Clayton Act, shall not apply to the business of insurance, or to acts in the conduct of such business.

(b) On and after July 1, 1948, the said Sherman Act shall not apply (1) to any agreement or concerted or cooperative action which prescribes the use of rates for insurance, insurance policy or bond forms or underwriting rules or plans if such rates, forms, rules, or plans are required, by the law of the State in which they are to be used, either to be approved by the supervisory official or

agency of such State having authority with respect thereto, or to be filed subject to disapproval by such official or agency; (2) to the use of any such rates, forms, rules, or plans which have been so approved or filed; (3) to any cooperative or joint service, adjustment, investigation, or inspection agreement relating to insurance, or to acts under such agreements; (4) to any agreement or concerted or cooperative action among two or more insurers to insure, reinsure, or otherwise apportion the risks taken by the parties to such agreement or any of them, or to issue policies or bonds with joint or several liability; (5) to any agreement or concerted or cooperative action with respect to the payment of insurance agents' or brokers' commissions; (6) to any agreement or concerted or cooperative action with respect to the collection and use of statistics or with respect to policy or bond forms; or (7) to any agreements or concerted or cooperative action providing for the cooperative making of insurance rates, rules, or plans, if such agreement does not require the use of such rates, rules, or plans.

(c) Nothing contained in this section shall render the said Sherman Act inapplicable to any act of boycott, coercion, or intimidation.

SEC. 5. Nothing contained in this act shall be construed to affect in any manner the application to the business of insurance of the National Labor Relations Act, as amended, or the Fair Labor Standards Act of 1938, as amended.

SEC. 6. As used in this act, the term "State" includes the several States, Alaska, Hawaii, Puerto Rico, and the District of Columbia.

SEC. 7. If any provision of this act, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of the act, and the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

APPENDIX C

"ORIGINAL McCARRAN-FERGUSON PROPOSAL"

S. 340

(79th Cong., 1st Sess., Jan. 18, 1945)

That the Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

SEC. 2.(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such act specifically so provides.

SEC. 3. Nothing contained in the act of September 26, 1914, known as the Federal Trade Commission Act as amended, or the act of June 19, 1936, known as the Robinson-Patman Anti-discrimination Act, shall apply to the business of insurance or to acts in the conduct of that business.

SEC. 4. For the purpose of enabling adjustments to be made and legislation to be adopted by the several States and Congress, until June 1, 1947, the act of July 2, 1890, as amended, known as the Sherman Act, shall not apply to the business of insurance, or to acts in the conduct of such business, and until January 1, 1948, the act of October 15, 1914, as amended, known as the Clayton Act,

shall not apply to such business or to acts in the conduct thereof.

(b) Nothing contained in this section shall render the said Sherman Act inapplicable to any act of boycott, coercion, or intimidation.

SEC. 5. Nothing contained in this act shall be construed to affect in any manner the application to the business of insurance of the act of July 5, 1935, as amended, known as the National Labor Relations Act, or the act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938.

SEC. 6. As used in this act, the term "State" includes the several States, Alaska, Hawaii, Puerto Rico, and the District of Columbia.

SEC. 7. If any provision of this act, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of the act, and the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected.